Commonwealth of Massachusetts
Department of Mental Health

Southeast Area Emergency Services Program Privatization Analysis

Office of the State Auditor Submission

January 2016

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DMH Southeast Emergency Services Program Privatization Analysis

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
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MARYLOU SUDDERS
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JOAN MIKULA
Commissioner

(617) 626-8000
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Certification in Support of the
Department of Mental Health's Proposal to
Privatize Its Southeast Area Emergency Services Program

In connection with the proposal of the Department of Mental Health (DMH) to privatize its Southeast Area Emergency Services Program, and in compliance with the Commonwealth's Privatization Law (M.G.L. c.7, §§52, *et seq.),* I certify, on information and belief, as follows:

1. I serve as the Commissioner of the Department of Mental Health.

2. DMH and the other parties to the privatization have complied with all provisions of the Privatization Law and of all other laws;

3. The quality of the services to be provided by the designated bidders is likely to satisfy the quality requirements of the statement prepared pursuant to M.G.L. c.7, §54(1) (i.e., the statement of services), and to equal or exceed the quality of services which could be provided by regular agency employees pursuant to M.G.L. c.7, §54(4);

4. The contract cost pursuant to paragraph M.G.L. c.7, §54(6) (i.e., the cost to privatize) will be less than the estimated cost pursuant to M.G.L. c.7, §54(4) (i.e., the cost of DMH continuing to provide the services), taking into account all comparable types of costs;

5. The designated bidders and their supervisory employees, while employed by the designated bidders, have no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest; and

6. The proposed privatization contract is in the public interest, in that it meets the applicable quality and fiscal standards set forth in M.G.L. c.7, §§ 52, *et seq.*

Signed and certified,

Joan Mikula, Commissioner
Department of Mental Health

Executive Office for Administration & Finance
COMMONWEALTH OF MASSACHUSETTS
STATE HOUSE ▪ BOSTON, MA 02133
(617) 727-2040

CHARLES D. BAKER
GOVERNOR

KRISTEN LEPORE
SECRETARY

KARYN E. POLITO
LIEUTENANT GOVERNOR

December 23, 2015

The Honorable Suzanne M. Bump
Auditor of the Commonwealth
One Ashburton Pl.
Boston, MA 02108

Re: Proposed Privatization of the Department of Mental Health's Southeast Area Emergency Services Program

Dear Auditor Bump:

I have received the proposed contract and supporting documents for the Department of Mental Health (DMH)'s proposal to privatize its Southeast Area Emergency Services Program. Based on a review of these documents by my office and additional answers from DMH officials, I certify under G.L. c. 7, § 54 (7) that:

(i) I have complied with all provisions of Section 54 of Chapter 7 and all other applicable laws;

(ii) the quality of the services to be provided by the designated bidders is likely to satisfy the quality requirements of the statement prepared pursuant to paragraph (1) of Section 54, and to equal or exceed the quality of services which could be provided by regular agency employees pursuant to paragraph (4);

(iii) the contract cost pursuant to paragraph (6) will be less than the estimated cost pursuant to paragraph (4), taking into account all comparable types of costs;

(iv) the designated bidders and their supervisory employees, while in the employ of said designated bidders, have no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest; and

(v) the proposed privatization contract is in the public interest, in that it meets the applicable quality and fiscal standards set forth in Section 54.

Should you or your staff have any questions about the proposal, please contact DMH's General Counsel, Lester Blumberg, at (617) 626-8233. If you have questions about this certification, please contact my Deputy General Counsel, Tori T. Kim, at (617) 727-2040 x35455.

Thank you for your consideration.

Sincerely,

Kristen Lepore
Secretary

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
25 Staniford Street
Boston, Massachusetts 02114-2575

CHARLES D. BAKER
Governor

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July 6, 2015

Honorable Suzanne M. Bump
Office of the State Auditor
State House - Room 230
Boston, MA 02133

Re: RFR Issued for Emergency Services Programs in DMH's Southeast Area

Dear Auditor Bump:

In accordance with the Guidelines issued by your office for implementation of the Commonwealth's Privatization Law, M.G.L. ch.7, §§52-55, please be advised that the Massachusetts Behavioral Health Partnership (MBHP), MassHealth's contracted managed behavioral health care vendor, is today issuing a Request for Responses (RFR) by which it will seek proposals to provide Emergency Services Program (ESP) services in the Department of Mental Health's (DMH) Southeast Area. All of MassHealth's contracted managed care entities will be required to contract with the same ESPs procured by MBHP.

ESPs are MassHealth covered benefits. Historically, ESP services in the Southeast Area have been provided by DMH employees. Under this plan, DMH employees will cease providing ESP services. Since these services are MassHealth Covered Benefits, MassHealth's contracted managed care entities, including MBHP, will be entering into new contracts for the provision of these services.

Information relating to the RFR, including a link to the RFR itself can be found in the attached announcement from MBHP. The date for receipt of bids on the RFR is September 1, 2015. Thereafter bidder selection will take place and a contract will be tentatively awarded. We anticipate submitting a complete certification package to the Office of the State Auditor for review in mid-fall.

If you have any questions in the meantime, please do not hesitate to contact my office regarding the cessation of ESP services provided by DMH. You may also address these questions to DMH's General Counsel, Lester Blumberg. He can be reached at (617) 626-8233 or lester.blumberg@state.ma.us. Please feel free to reach out to Emily Sherwood, the Director of the MassHealth Behavioral Health Programs or MassHealth's Chief Counsel, Sharon Boyle, with questions regarding MassHealth and the ESP services MassHealth's contracted managed care entities will be providing. They may be reached at (617) 573-1759 or (617) 573-1662 respectively.

Thank you very much for your attention.

Sincerely,

Joan Mikula,
Commissioner

cc: Emily Sherwood
Director of the MassHealth Behavioral Health Programs

Sharon Boyle, Esq.
MassHealth Chief Counsel

Executive Summary

I. Introduction

The Department of Mental Health (DMH) proposes to privatize its current state- operated Emergency Services Program (ESP) in the DMH Southeast Area of the state. Under this proposal and as described below, ESP services in the Southeast Area would be provided through managed care entities (MCEs) under contract to the Executive Office of Health and Human Services.[1] This document and the attached exhibits demonstrate that DMH has fully complied with the Commonwealth's privatization law, M.G.L. c.7, §52, *et seq.* (Privatization Law), and that the proposed privatization would result in first year savings to the Commonwealth of approximately $6,400,000, with successive year savings of similar amounts without a reduction in the quality or level of services provided.[2] The private providers would be required to meet or exceed the same performance standards that DMH has been required to meet as an ESP provider.

The ESP is a Medicaid-covered behavioral health service available to MassHealth members, uninsured individuals, and others experiencing psychiatric emergencies. The program offers 24 hours per day, seven days per week crisis assessment, intervention, and stabilization services.[3] Throughout the state, with the exception of the DMH Southeast Area, these services have been provided by private contractors for nearly 20 years. The service areas in which DMH provides this Medicaid service comprise four of the 21 ESP service areas statewide.

II. Background

A. The Roles of MassHealth and MBHP

The Executive Office of Health and Human Services, through MassHealth, administers the Commonwealth's Medicaid program. With both state and federal funding, MassHealth pays for health care for a substantial portion of low and medium income people living in Massachusetts. MassHealth behavioral health services are provided by a network of providers that are under contract with one or more of the state's MCEs, and in most cases directly with MassHealth. MassHealth pays MCEs an actuarially determined per-month capitated rate for each member to cover all behavioral health services the member might require.

To ensure provision of consistent, high quality ESP services across the state, MassHealth has contracted with the Massachusetts Behavioral Health Partnership (MBHP) to procure and

[1] The MassHealth MCEs include the Massachusetts Behavioral Health Partnership, Boston Medical Center HealthNet Plan, CeltiCare Health Plan of Massachusetts, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Network Health.

[2] Public Consulting Group of Boston provided extensive assistance in preparing this proposal, analyzing data, performing cost analyses, and ensuring compliance with the Privatization Law.

[3] The ESP performs crisis assessments; short-term crisis counseling; crisis intervention; crisis stabilization; medication evaluation; and client observation services. The ESP also includes a Mobile Crisis Intervention (MCI) service specifically for children. A more comprehensive description of the ESP is included in the MBHP/MassHealth contract, attached in Section 2: "Written Statement of Services" Appendix VII

oversee a network of providers who are qualified and have the capacity to provide ESP services in accordance with the service specifications and quality measures established by MassHealth. Each MCE is required to contract with this same network of providers to ensure that ESP services are available to all who qualify for them. As with its other providers, each MCE negotiates a separate contract with the ESP providers, paying rates determined by those separate negotiated contracts. The MBHP/MassHealth Contract is attached as part of Section 2: "Written Statement of Services" Appendix VII.

All ESP providers, including DMH, are required to meet MBHP's quality and performance standards, which reflect the MassHealth Medicaid requirements. Through quality management, as explained more fully below, MBHP ensures that ESP providers meet these standards.

B. DMH's Provision of Emergency Services

DMH has three state operated community mental health centers (CMHC) in the southeast area of the state: The Brockton Multi-Service Center (BMSC) located in Brockton; the Cape Cod and the Islands Community Mental Health Center (CCICMHC) located in Pocasset; and the Dr. John C. Corrigan Mental Health Center (JCCMHC) located in Fall River. All three CMHCs provide a variety of state operated services, including locked acute hospital services (at CCICMHC and JCCMHC), and community support services for adults, children and adolescents. DMH employees provide ESP services connected with these sites and at a separate Taunton/Attleboro site. These four ESPs are among the 21 ESP service sites throughout the Commonwealth. The others are all managed by MBHP.

Nevertheless, some of the DMH emergency services components are already provided by private providers. For example, as part of its current service delivery model, DMH contracts with a private provider for Crisis Stabilization beds for Cape Cod and the Islands. In addition, ESP services on Martha's Vineyard and Nantucket are delivered by a private provider under contract with DMH.[4] Also, to ensure adequate coverage for its child/adolescent mobile response, DMH has had a contract for relief coverage with a private provider.

III. The Proposed Privatization

A. The Privatization Contract

MassHealth has amended its contract with MBHP to require MBHP to expand its network of contracted ESP providers to include the Southeast Area of the state. This expansion will take effect upon approval of the State Auditor in accordance with the Privatization Law. The amendment requires MBHP to enter into contracts that comply with all Privatization Law provisions concerning quality of services, employee salaries, benefits and job opportunities for existing state workers. The term of this amendment coincides with current term of MassHealth's contract with MBHP, which runs to June 30, 2017.

[4] These service arrangements were in place prior to enactment of the Privatization Law or are for services not previously provided by state employees.

On July 6, 2015, MBHP issued a "Request for Responses" (RFR) for entities interested in providing the ESP services currently provided by DMH in its four emergency services areas.[5] The RFR met the requirements of the Privatization Law by including provisions regarding wages, benefits, hiring, etc.

In response to the RFR, five potential providers submitted a total of twelve bids for review, as follows: Brockton – 4 bids; Cape Cod and the Islands – 2 bids; Fall River – 3 bids; and Taunton/Attleboro – 4 bids. The Service Employees International Union, Local 509, which currently represents a portion of DMH employees performing ESP work gave notice of its intent to bid on the ESP services and requested resources from DMH to assist it in this effort. DMH provided the union with the resources it requested, which comprised release time for requested employees and extensive data. The Union submitted a several page bid proposal that failed to meet minimum requirements for consideration under the RFR.

After an initial review, an MBHP evaluation committee analyzed each qualifying bid proposal. Based on the committee's evaluation, MBHP recommended the following two organizations to provide ESP services in the Southeast region of the state:

- Community Counseling of Bristol County (CCBC) for the Brockton and Taunton/Attleboro catchment areas; and

- Boston Medical Center (BMC) for the Fall River and Cape Cod and the Islands catchment areas.

The two recommended providers meet the requirements set forth in the RFR and satisfy all Privatization Law requirements. Contracts will be executed upon completion of the review required under the Privatization Law. Copies of the proposed provider contracts for emergency services, as well as each proposed provider's regulatory certification under § 54(7) of the Privatization Law, are set forth in Section 3: "Model Emergency Services Agreement between MBHP and Selected Providers."

[5] The existing private network was last procured by MBHP in 2008. This RFR process was substantially similar and followed the same evaluation and selection procedures.

B. The Cost of the Proposed Privatization

MassHealth contracts with MBHP and the other MCEs to cover all behavioral health services, including ESP services, to their enrollees. MassHealth pays MCEs an actuarially sound capitated rate (fixed dollar amount per person) to provide services covered under the contract.

Under the proposed privatization, the Commonwealth, via MassHealth, would increase these capitated "per member per month" (PMPM) payments to the state's MCEs to expand their networks to provide appropriate ESP coverage for members who access services in the Southeast Area.

DMH has worked with MassHealth and its actuary, Mercer, LLC,[6] to determine the marginal increase in the PMPM necessary to include the services attributable to those individuals receiving services from the DMH Southeast Area ESPs. As a result of this analysis, it was determined that the increase in the PMPM to expand MBHP's ESP network to the Southeast Area would be $0.42 on payments made to MBHP, which is the behavioral health carve-out vendor for the MassHealth Primary Care Clinician Plan, and $0.88 to the state's other MCEs. Multiplying these amounts by the number of covered MassHealth members results in a total increase in the capitated rate cost per year of $3,410,673.

An additional $386,746 is also included in the calculation of the Contract Price which accounts for the increase in the Interagency Service Agreement (ISA) between DMH and MassHealth to cover the costs of the uninsured population which would be accessing private vendors following a possible privatization. This dollar amount is based on the estimated volume of these uninsured encounters and the typical costs associated with each.

Finally, an additional estimate of $1,819,752 was also included to cover the costs associated with individuals receiving future evaluations under a privatized system who are not enrolled in MCE care but are instead a part of the program's current fee-for-service (FFS) population. This total amount was similarly calculated based on estimated volumes and typical reimbursement costs.

Two additional costs are associated with the cost of the proposed privatization, they are costs associated with unemployment benefits resulting from state employee personnel shifts ($954,158) as well as a single one-time start-up cost ($60,000) estimated by DMH as needed to ensure that the vendor chosen through the privatization would be capable of quickly and effectively ramping up their operations to cover the needed services at the required quality levels as proscribed through the RFR.

Ultimately the "Contract Performance Cost," as labeled in Form 3 of this study, is therefore a summation of the projected increase in both the component costs associated with the contract price ($5,617,171) as well as the additional transition costs associated with the privatization ($1,014,158) for a total of $6,631,329 for the first year of the contract.

[6] Mercer, LLC is an international actuarial firm that provides services to MassHealth and other state agencies.

C. DMH's Cost to Provide the Services

In accordance with the Privatization Law, DMH has also considered its own cost to continue to provide the ESP services in the southeast, including an analysis of potential efficiencies which could serve to reduce the program's overall cost. This analysis is set forth in Forms 2 of this submission packet.

The total estimated cost to run the ESP program in the southeast during Fiscal Year 2016 (also labeled as the 'avoidable cost' to the Commonwealth in Form 2) at a level which represents the program's most efficient operation is $13,024,296.

This total cost estimate is based on three primary factors. First, the historic costs associated with running the program which were reviewed through several sources. Second, an analysis of which of these costs could be considered "avoidable" if the program is privatized (e.g., excluding certain overhead costs incurred by the Commonwealth regardless of the privatization). And third, an analysis of what costs could be saved across the program should certain program structures be adjusted to realize any efficiencies in the program's overall operations.

This final component, known as the Management Study, built upon findings of a previous DMH internal operations review[7], in addition to information gathered through interviews with key program and policy leaders within the state-operated ESPs as well as suggestions provided by the SEIU.

	Year 1	**Year 2**	**Year 3**	**Total Projected Savings**
Shared Program Call Center	$441,935	$644,569	$390,239	**$1,476,743**
On-Call and Overtime Restructuring	$223,877	$0	$0	**$223,877**
Runaway Assistance Program	$141,904	$0	$0	**$141,904**
Staff Realignment	$43,365	$71,890	$10,985	**$126,241**
Revenue Recovering Maximization	$2,554	$25,268	$61,743	**$89,565**
Distribution of Laptops	$50,485	$0	$0	**$50,485**
Total Savings	**$904,120**	**$741,727**	**$462,967**	**$2,108,816**

While a number of scenarios were examined, DMH identified the six primary feasible interventions listed in the table above that could be implemented over the next several years to yield cost savings and increase operational revenue.

[7] Madenwald, K., Massachusetts Department of Mental Health, Emergency Service Program Performance Improvement Project (April 2, 2014).

DMH estimates that the implementation of identified efficiencies would save $904,120 within the first year $2,108,816 over a full three year period.

D. Cost Comparison

DMH compared the In-House Cost Estimate from Form 2 (Fiscal Year 16 $13,024,296) with the Contract Performance Costs from Form 3 (Fiscal Year 16 $6,631,329) to determine the savings to the Commonwealth by privatization of the four DMH state-operated ESPs. DMH estimates the Commonwealth would save $6,392,967 in the first year under a privatized program. This analysis is set forth in Form 1, with detailed supporting information included in the submission packet's supporting documentation.

The savings to the Commonwealth of this privatization is attributable to a variety of factors. It reflects the difference between the cost to DMH to provide the ESP services and the significantly reduced cost to the Commonwealth to provide the ESP services through MassHealth and its contracts with the Managed Care Entities. The MassHealth contracted ESP services benefits from efficiencies unavailable to DMH. DMH ESPs provide approximately 12,500 ESP encounters yearly across the four program sites. In contrast, MassHealth, through its contracts, provides over 124,000 similar encounters statewide. With more centralized management of all encounters, the administrative cost per encounter is substantially lower within the MassHealth program. By shifting DMH's 12,000 encounters under the MassHealth program, the administrative cost per encounter will immediately decrease, resulting in a significant program savings.

Furthermore even after implementing efficiencies as described in the Management Study, DMH's labor costs remain significantly higher than provider labor costs. This is true even accounting for the cost of health insurance benefits and salary requirements contained within the Privatization Law.

E. Union Engagement/SEIU-Proposed Contract Amendments and Efficiencies

On March 4, 2015, DMH, through the EOHHS Labor Relations office, notified all unions representing DMH ESP staff members of its intent to pursue the privatization of ESP services. One of the unions representing DMH's ESP staff members, SEIU, engaged DMH in discussions related to the proposed privatization. The union had several data requests and DMH supplied the Union with requested information.

On July 6, 2015, DMH telephoned all affected unions and notified them of MBHP's issuance of an RFR for the ESP services. On July 7, 2015 DMH memorialized this in letters to the unions. Shortly thereafter, MBHP posted the RFR on its web site. SEIU thereafter sought resources to be able to respond to the RFR and DMH provided the additionally requested resources.

DMH met multiple times with SEIU to discuss the proposed privatization, including as recently as October 16, 2015. SEIU offered various proposed programmatic efficiencies that, by the

Union's calculations, would save DMH between $700,964 and $742,564 per year. The proposal included:

- Certain changes to "call back" and "stand-by" pay;
- A projected reduction of overtime by 2/3, achieved by filling open positions, allowing employees to receive "compensatory time" in lieu of overtime, and allowing for flexible shift scheduling;
- Eliminating a Director position; and
- Replacing two other Directors with lower-graded SEIU members.

To the extent deemed feasible, these proposed efficiencies were included as part of DMH's Management Study. DMH does not necessarily agree with the projected savings that SEIU suggests could be achieved. Regardless, the Union's projected savings (up to $742,564 per year) are far less than the savings expected from privatization ($6,392,967 per year).

Notwithstanding this significant gap, DMH has indicated that it will continue to meet with the Union if it wishes to offer additional proposals. Furthermore, DMH anticipates bargaining with the Union in efforts to minimize any adverse impact on staff resulting from a privatization.

In addition to the above conversations with SEIU, DMH offered to all unions representing ESP employees a plan intended to provide cash incentives to employees who would agree to stay through the date of transition to new providers. The unions, however, did not avail themselves of this opportunity.

DMH also has indicated to SEIU that it would be willing to try to place in other vacant positions – at DMH or at other agencies – any employees who might be losing a position on account of privatization. To date, SEIU has indicated that it does not wish to pursue this.

In addition, DMH held on-site sessions with its Employee Assistance Program provider to offer support to any employees who wished to avail themselves of that service.

F. Quality of Services

MBHP under the direction of MassHealth and in consultation with DMH, expends substantial resources ensuring the quality of services provided by its network of providers, and the providers themselves are expected to devote substantial resources to ensuring quality care. MBHP's quality management plan is set forth in Section 8 of the MBHP/MassHealth contract attached as part of Section 2: "Written Statement of Services" Appendix VII.

Required activities include, but are not limited to, managing data regarding quality, developing and using evaluation tools to assess quality, reporting on quality management, maintaining quality management staff, training of staff, conducing assessments of user satisfaction, preparing annual assessment reports, conducting quality improvement projects, and a variety of other activities which actually exceeds DMH's quality management activities.

MBHP's ESP performance standards are applied to private providers just as they are currently applied to DMH. MBHP's data over time demonstrates that MBHP's contracted providers and DMH-provided ESP services perform at equivalent levels of quality. MBHP quality data is attached as part of Section 2: "Written Statement of Services" Appendix VI.

IV. Conclusion

As the documentation demonstrates, DMH's proposal meets all of the requirements of the Commonwealth's Privatization Law and will result in the provision of high quality ESP services to the citizens of the Southeast Area of the state at a substantial savings to the Commonwealth.

Written Statement of Services for Emergency Services Programs

I. Introduction

The Massachusetts Behavioral Health Partnership (MBHP) intends to secure a contract on behalf of MassHealth for the delivery and management of Emergency Services Programs (ESP) in the Southeast region. These services are currently provided by the Department of Mental Health (DMH).

In accordance with the June 2012 Guidelines for Implementing the Commonwealth's Privatization Law as required under Chapter 296 of the Acts of 1993, this document lays out the necessary services which are currently covered under DMH's ESP program in the Southeast region. This document also outlines all expected performance measures via the program's detailed specifications as well as quality measures that will be used to measure the effectiveness of the program following its transition.

A. Mission Statement

The mission of the Emergency Services Program (ESP) is to deliver high quality, culturally competent, clinically and cost-effective, integrated community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, rehabilitation, and recovery.

B. Guiding Values

The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows an individual to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters the ESP provides a core service of crisis assessment, resolution-focused treatment intervention, and stabilization. These encounters must also include crisis behavioral health assessments and offer short-term crisis counseling that includes active listening and support.

The ESP provides solution-focused and strengths-oriented crisis intervention (i.e. active listening, support, brief counseling) aimed at working with the individual and his/her family and/or other natural supports to bring relief to the crisis state, reduce symptoms, improve functioning, reduce harm, promote understanding of the current crisis, resolve ambivalence, identify solutions, and collaborate on decisions to access resources and services for comfort, support, assistance, and treatment.

As agreed upon, and after engaging the individual (and parent/guardian when applicable) in an informed, shared decision-making process, ESP arranges the behavioral health services that the individual selects to further treat his/her behavioral health condition based on assessments completed, declared readiness and preference, and the individual's demonstrated medical need. The ESP coordinates with other involved service providers and/or newly referred

providers to share information (with appropriate consent) and makes recommendations for a treatment plan. The ESP also provides the individual and his/her family with resources and referrals for additional or alternate services and supports, such as recovery-oriented and consumer-operated resources in their community.

While it is expected that all ESP encounters include the basic components outlined in this document, these services also require flexibility in the focus and duration of many additional tasks associated with initial interventions, an individual's participation in treatment, and the number and type of follow-up services. ESP services are directly accessible to individuals who seek behavioral health services on their own and by those who may be referred to the program. ESP services are preferably community-based in order to bring treatment to individuals in crisis, allow for consumer choice, and offer medically necessary services, in the least restrictive environment, that are most conducive to stabilization and recovery.

C. Program Goals

The goals of the Emergency Services Program (ESP) are as follows:

Treatment Level of care: Local ESPs will operate as a discrete treatment level of care that delivers comprehensive crisis behavioral health services, including but not limited to crisis assessments, resolution-focused interventions, and stabilization services including CCS for adults as well as community-based stabilization for youth for a period of up to 7 days. The expectancy is that effective ESP treatment services will increase coping and functioning, decrease risk and thus diminish the need for a more restrictive level of care. This includes the capacity and competency to address the needs of special populations, including children and families. ESP is NOT a screening service that is limited to assessing eligibility for various levels of care.

Transformative: ESPs are not only committed to achieving established outcomes but also to serving as a local driver in transforming the way behavioral health crisis services are accessed and delivered across the community. This includes leading, supporting and contributing to initiatives, forums and collaboratives that increase the capacity and competency of community partners (community treatment providers, hospitals, schools, state agencies, law enforcements, courts, homelessness and housing services, local governments and businesses) in preventing and supporting individuals in crisis, assuring care continuity before, during and after an episode of crisis.

Timely: ESPs will respond to all requests for crisis assessment, intervention, and stabilization in a timely fashion, as required in Appendix II: ESP Performance Specifications and Appendix III: Quality Indicators. These performance specifications are intended to be responsive to the individual or their caretaker's sense of urgency and to prevent adverse impacts which treatment delays may have on individuals and families. Timeliness must be achieved through effective staffing, geographic location and dispatch strategies and not be compromising the

delivery of a quality, complete treatment service for one person in order to begin in a timely fashion with the next person.

Community-based: ESPs will provide crisis behavioral health services in the community, through Mobile Crisis Intervention services for youth/families and adults, accessible community-based locations, and adult Community Crisis Stabilization (CCS). These programs will ensure that ESP services reach those individuals in need, allow for consumer choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery.

Diversion: Through an array of initiatives and in ways that are experienced as beneficial to individuals in crisis, ESPs will shift utilization from more restrictive settings when that setting is not necessary, effective or desirable for the person in crisis, particularly hospital emergency departments (ED) and inpatient psychiatric care. ESPs will interrupt patterns of community over-reliance on hospital EDs to the extent permitted under applicable state and federal law. ESPs will focus on becoming the first point of contact in the event of a behavioral health crisis in an effort to shift volume away from hospital ED use. ESPs will also seek to maximize the use of community-based alternatives consistent with medical necessity criteria in lieu of admissions to inpatient psychiatric care. ESPs achieve this practice shift through effective engagement/collaboration and delivery of resolution-focused interventions that will lessen demand for higher levels of care, rather than by restricting access or imposing other plans.

Recovery-oriented: ESPs will support resiliency, rehabilitation, and recovery of all individuals by integrating mental health, substance use, and co-occurring recovery and rehabilitation principles and practices throughout the service delivery model to continually emphasize recover oriented care.

Clinical quality and consistency: ESPs will provide medically necessary and clinically appropriate behavioral health crisis assessment, intervention, and stabilization to all individuals they serve, consistent with their clinical presentation, culture, and special needs. This level of clinical care will be offered consistently across all ESPs statewide.

Cultural competence: ESPs will provide culturally and linguistically appropriate behavioral health services by ensuring that the content and process of the crisis assessment, intervention, and stabilization services are performed in culturally sensitive ways, recognizing among other things, an individual's preferred language and mode of communication.

Linkages: ESPs will be knowledgeable about community-based outpatient, diversionary, and inpatient mental health and substance use services, and will develop relationships with the providers of those services, ensuring effective consultation and referral processes and seamless transfer and coordination of care.

Information: MBHP will provide data to enable the local ESPs, MBHP, MassHealth, and DMH to manage the emergency behavioral health system effectively.

II. Statement of Services

The ESP provides crisis behavioral health services 24 hours per day, seven days per week, 365 days per year (24/7/365) to individuals who are experiencing a behavioral health crisis. The services provided by ESPs represent the hub of the behavioral health community safety net. The primary covered services included in the program are:

- Crisis screening (assessment)
- Short-term crisis counseling
- Crisis stabilization
- Medication evaluation

While this "core" set of ESP service is referred to throughout this document as "crisis assessment, intervention, and stabilization," this term should be considered as inclusive of all services listed above.

A. Program Service Scope

The scope of the ESP is defined in terms of the services that are provided as well as the populations served by the program. The following parameters define the scope relative to each of these variables.

1. Population scope

- *In scope*:
  - Age:
    - ESP services are available to individuals of all ages.
    - Adult CCS, operated by the ESP, is available to individuals 18 years of age and older.
  - Diagnosis
    - ESP services are available to individuals who present mental health, substance use, and/or co-occurring conditions.
    - Adult CCS is available for individuals with mental health or co-occurring conditions.
  - Payer
    - ESP services, including adult CCS services, are available to all uninsured individuals as well as those enrolled in, or covered by, the following public payers: MassHealth plans, including the PCC Plan (MBHP), the MassHealth-contracted MCEs, MassHealth fee-for-service; DMH only; Medicare; Medicare/Medicaid; and One Care and Care Plus.
- *Out of scope:*
  - Diagnosis
    - Adult CCS services will not be available to individuals if the sole/primary focus of the crisis intervention is a substance use condition.
  - Payer
    - Payment will not be provided to ESPs for ESP or adult CCS services for individuals with commercial insurance. This contract does not mandate ESPs to provide ESP

and/or adult CCS services to this population, and any resulting contract with MBHP shall not require ESPs to provide ESP and/or adult CCS services to such populations. ESPs are encouraged to seek contracts with commercial payers for the provision of ESP and adult CCS services to their members.

2. Service scope

- *In scope:*
  - Community-based behavioral health services that provide a core service of behavioral health crisis assessment, intervention, and stabilization to all utilizers of ESP services, at all ESP locations and through all ESP services components, including but not limited to:
    - Mobile Crisis Intervention, for youth under age 21, as a component of the Children's Behavioral Health Initiative (CBHI)
    - Adult Mobile Crisis Intervention services.
  - Adult Community Crisis Stabilization (CCS) services for ages 18 and older.

B. Core Competencies

All ESP services

ESP providers demonstrate the capability to meet the following competencies:

Crisis services

The fast-pace and unpredictable demand for 24/7/365 crisis services requires that selected ESP providers pay very close and ongoing attention to service flow and staffing patterns. Core competencies include:

- Ability to deliver services requiring crisis response on demand
- Success in meeting response requirements in a crisis environment and ability to comply with response-time requirements mandated in Appendix II: ESP Performance Specifications and in Appendix III: Quality Indicators
- Success in managing resources to respond quickly to fluctuations in demand in a crisis environment (through use of strategies such as cross-training, use of on-call staffing, and non-traditional scheduling)
- Efficiency in the dispatching of individuals or teams, managing on-site crisis service and crisis stabilization capacity and referral processes
- Ability to hire, develop, and retain staff who are competent at mobile crisis response, are skilled at risk management, and are able to operate in an independent and self-directed fashion
- Use of electronic, telephonic, and other technological tools that optimize efficiency, reduce risk, and/or otherwise support achievement of results

Upstream intervention

As is the case with most healthcare interventions, early identification and treatment of symptoms can often prevent a full-blown crisis episode. Therefore all ESP programs must contain the following core competencies:

- A commitment to intervention at the earliest possible point in the crisis episode in a cost effective manner that contributes to the prevention of adverse outcomes, such as arrest, filing for an emergency petition, loss of housing, family stress, or injury to self or others
- Commitment to facilitating rapid access to a range of urgent treatment services
- Commitment to collaborating with other systems in managing behavioral health crises when risk of out-of-home placement is high

Recovery-oriented treatment

To achieve optimal results, it is essential that ESP providers move fully from a deficit/disability construct to one that is strengths-based and client-driven. In order to effectively accomplish this, ESP programs must deliver services in a manner that is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) consensus statement on mental health recovery, which is provided in Section F, Recovery-Oriented Services.

Cultural and linguistic competence

The Substance Abuse Mental Health Services Administration (SAMHSA) defines cultural competence as "an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations." The potential consequences of inadequate attention to and insufficient attainment of, cultural and linguistic competency are particularly great for ESPs given the high-risk nature of the work and relative lack of alternatives for seeking crisis intervention. Therefore all ESP providers must:

- Provide services in a culturally and linguistically competent manner, including access to informal and formal supports reflecting the family's cultural and linguistic preferences, including bilingual professionals, materials and interpreters.
- Hire, develop, and retain culturally and linguistically competent staff
- Commit to continuous learning in the area of cultural competence, reflected in training curricula, supervision, and performance evaluation at all levels of the organization
- Commit to continuous evaluation of the service environment, written materials, communications, facilities, and appearance of staff from a cross-cultural perspective in an effort to promote an open, welcoming, and accepting environment

Mobile (non-hospital) response: *the preferred service delivery model*

The preferred environment for the delivery of crisis services is in the home or other natural community setting, which is intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs), lessen the expectancy of and reduce the likelihood of use of restrictive dispositions such as psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner. Therefore ESP providers must:

- Be able to implement a service delivery model that achieves the provision of the majority of ESP services for adults and all MCI services for youth in the home or other natural

community setting. (Crisis assessments for youth only occur in a hospital emergency department (ED) if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuses required consent for service in home or alternative community settings; or if request for Mobile Crisis Intervention originates from a hospital ED.)

- Support the development of procedures and decision-making tools that promote delivery of ESP services in the community and outline when use of ED/911 is indicated.
- Arrange for services to be alternatively delivered in the ESP's community based location or other setting consistent with consumer/family preferences, time of day, or clinical considerations.
- Tailor crisis behavioral health services in a home/community environment.

Least restrictive treatment

As is the case elsewhere in the nation, there is heavy statewide reliance on EDs as the providers of first contact in the event of a behavioral health crisis. Persons who receive behavioral health crisis services in the ED are more likely to be hospitalized than those treated in the community. While EDs are an important component of the crisis continuum, most behavioral health crises can be more effectively addressed in the community. Doing so adheres to the principle of least-restrictive treatment, while ensuring the provision of medically necessary services, and will increase the likelihood of referral to appropriate, timely, and least-restrictive ongoing medically necessary services, consistent with individual and community safety as follow-up to the crisis service. Therefore all ESP providers must:

- Commit to care that is voluntary and consumer-directed and is delivered in, or as close to, home as possible
- Deliver care that is minimally disruptive
- Create a service pathway that screens for the need to refer up to, rather than step-down from, hospital-based emergency care

Effective use of treatment resources

Effective utilization management increases the likelihood that treatment options are available when needed. Without a broad continuum of services and resources, the likelihood increases that scarce resources will be misappropriated just to ensure that some service is provided. Community Crisis Stabilization services are beneficial only to the degree that there are regular openings, and that they remain true to their intended purpose. Programs that seek to grow and effectively utilize resources, such as reserved appointment slots for rapid urgent referrals (in or outside of own agency), broaden the continuum of resources that they can offer to the persons they serve, increase the likelihood of a discharge home, and increase consumer satisfaction. Because of the volume and variety of needs of those served, ESPs are well-positioned to identify persons in need of specialized services such as Enhanced Acute Treatment Services (E-ATS),
Intensive Care Coordination (ICC), In-Home Therapy, or Program of Assertive Community Treatment (PACT), and should develop referral relationships and processes that will fast-track linkage. Therefore all ESP providers must have:

- A commitment to ensuring medically necessary services and the right level of care for the right length of time
- The ability to measure supply of services and demand for those services, and implement strategies, in collaboration with MBHP, to ensure access
- An assurance to efficient and timely discharges from the ESP's community-based location and CCS to maximize service capacity
- 24/7/365 ESP access to capacity information at CCS and other outpatient and diversionary levels of care
- 24/7/365 ESP linkage capability with CCS and other outpatient and diversionary levels of care

Intersystem knowledge, planning, and affiliation

While ESPs might be the most visible provider of crisis behavioral health services, a community is not well-served if ESPs bear the full burden of providing an effective safety net. The bulk of crisis work should be focused on prevention and very early identification of symptoms by those entities that are serving persons/families in an ongoing capacity. Cross-system education will increase competency in effective use of ESP services. For example, advances in mental health system collaboration with, and training of, law enforcement officers have led to very exciting programs and outcomes in this state and elsewhere. Therefore ESPs must

- Demonstrate broad knowledge of the community behavioral health system via:
  - Excellent collaborative skills – uses collateral information effectively
  - Knows what services are provided in the community, how they are funded, and how clients access them; develops professional relationships with peers in these agencies
  - Able to use system resources in order to complete work in an efficient fashion and to facilitate access to services by clients
- Knowledge of referral streams into the crisis system
- Identification and amelioration of barriers to early, upstream intervention
- Strategic initiatives to strengthen collaboration with key partners in crisis prevention, early intervention, hospital and jail diversion, and placement disruption. Partners include, but are not limited to:
  - Law enforcement entities
  - State agencies including child and elder protective services and juvenile justice
  - Schools
  - Residential treatment facilities
  - Hospitals
  - Primary care clinicians and health centers

Commitment to Continuous Quality Improvement

Though ESPs are the primary provider of community-based behavioral health crisis services, adopted strategic goals should reflect both agency-specific and systemic outcomes, indicators, and measures. The success of the ESP in meeting its service-specific and agency-specific goals, and contributing to the achievement of systemic outcomes in its communities, depends greatly on the degree to which the ESP has effectively engaged the broader system in supporting and

strengthening the community crisis continuum and the service/referral pipelines both into and out of crisis services. ESP providers must therefore:

- Use continuous quality improvement processes, including outcomes measures and satisfaction surveys, to measure and improve quality of care and service delivered to persons served, including youth and their families, and services to special populations
- Routinely track overall and discipline-specific service volume and type by day and by shift so that staffing and service patterns are optimally efficient
- Routinely analyze trends in referral-in/referral-out patterns, and develop specific measures aimed at reducing overuse of hospital EDs
- Evaluate service penetration patterns by race, age, culture, geography, and other variables for indicators that services may not be viewed as being accessible
- Plan to impact and track strategic objectives to achieve or contribute to the achievement of:
  - Increased ED diversions
  - Reduced use of inpatient psychiatric treatment
  - Reduced commitments
  - Increased criminal justice diversion for youth and adults, to the extent resulting from the youth/adult's behavioral health condition
  - Increased diversion from out-of-home placement
  - Increased volume of risk management/safety plans and WRAP plans filed with ESP
  - Achievement of linkage timeframe targets in areas such as:
    - Urgent psychiatric appointments
    - ICC linkages
    - Admission to diversionary services, including CCS, CBAT, In-Home Therapy, EATS, and ATS
- Establish/strengthen affiliations and collaborations as measured by
  - Impact of partnership on achieving strategic objectives
  - Adoption of shared outcomes

C. Clinical competencies

ESP providers must also possess significant clinical competencies in order to effectively deliver core and ancillary services which fall under the ESP program. All ESP Programs therefore must possess satisfactory levels of clinical competency in the following areas:

<u>Clinical assessment</u>

All ESPs must demonstrate an ability to perform a focused and comprehensive assessment of persons in crisis due to a mental health and/or substance use condition that includes:

- Understanding of the presenting problem as defined by the person in crisis, family, referral source, and/or other stakeholders
- Mental Status Exam, including assessment of previous and current risk of harm to self or others

- Assessment of current or past use of substances and indications for arranging immediate medical treatment or medical follow-up, including the capacity to screen for intoxication or withdrawal
- Assessment of other medical conditions and indications for immediate medical treatment and medical follow-up
- Multi-axial diagnosis (DSMV)
- Specific identification of biological, psychological, and all social domain stressors and strengths (that either increase or decrease risk)
- Multi-system involvement or needs (i.e., educational system, child/adult/elder protective services, juvenile justice, criminal justice, primary care, military/veteran, or homelessness services)
- Assessment of strengths, resources, capacities, past successes, and natural supports
- Level-of-care assessment

ESPs should also have a developed protocol for multi-disciplinary evaluations, based on the comprehensive assessment of multiple contexts including:

- Comprehension of normal child, adolescent, and adult development
- Comprehension of grief and trauma

<u>Diagnostic accuracy</u>

- Comprehension of, and ability to use, the Diagnostic and Statistical Manual
- Knowledge of diagnostic, medical, substance-related, developmental, and environmental differentials that must be considered
- Awareness of the differences in manifestation of mental health and substance use conditions in children versus adolescents, versus adults

<u>Client engagement and de-escalation skills</u>

- Able to engage client in a manner that is both professional and calming
- Able to identify cues that might indicate the best means of communicating with the client
- Able to identify, consider, and respect cultural/lifestyle differences and the impact on treatment
- Able to work with clients in their natural environment
- Ability to modify engagement techniques to meet the individualized needs of the client
- Skilled in verbal and non-verbal de-escalation techniques

<u>Risk assessment and management skills</u>

ESP services are widely accessible, and persons seek these services due to crises that are self-defined. Clinical presentation varies dramatically as it relates to the apparent significance and impact of stressors; the coping ability of the person/family in crisis; the nature and degree of risk; the co-morbid presence of a medical condition or disability; the degree to which care is being sought voluntarily; the age, culture, and life experience of the recipient and family; and the concurrent involvement in other systems. Competent crisis providers are in every way respectful of the perspective of the service recipient, family, and other stakeholders in

assessing risk and identifying resources and solutions. Crisis assessments, though focused in nature, must address a broad array of risks, including those present in the daily living environment. Therefore ESP providers must:

- Establish a culture that "risk management is everybody's job"
- Be able to identify potential risks to client or others, and to develop and implement a plan of action to reduce those risks
- Recognize lethality risk in special populations
- Use problem-solving skills by considering various options and potential outcomes in a creative yet timely manner
- Identify the need for, seeks, and utilizes supervision/consultation
- Seek consensus-driven dispositions

Recovery-promoting treatment approach

Recovery-promoting treatment approaches are those that instill hope; capitalize upon the strengths of the person and his or her family/support system; are self-directed; are aimed at enhancing problem-solving, coping, and other competencies; and are highly individualized and collaborative. Recovery-oriented processes recognize and respect that change occurs in nonlinear stages, and effective providers assess the level of change-readiness and pair stage-effective intervention techniques accordingly. Therefore ESP providers must:

- Use interventions that are compatible with rehabilitation and recovery principles and likely to promote self-help, including techniques found in:
    - Developing authentic relationships
    - Risk management that includes dignity of risk concepts
    - Collaboration in assessment and disposition planning
    - Wraparound care planning
    - Solution-Focused Therapy
    - Cognitive Behavioral Therapies
    - Stages of Change
    - Motivational Interviewing
    - Shared Decision-Making
    - Illness Management and Recovery
    - Peer-to-Peer Support
- Refer to recovery-oriented programs, including peer-led services
- Preserve the right to refuse treatment when at all possible.
- Strive to achieve a consensus disposition.

Capacity and competency to treat specific populations

Unique competencies are required to assess and intervene with specific populations. Well-developed policies and procedures, combined with effective training and supervision and appropriate referral pathways for special populations will improve treatment outcomes, increase individual satisfaction, and decrease risk. Therefore ESP providers must be capable of providing services to these special populations.

D. Mobile Crisis Intervention

- In order to qualify to provide the Mobile Crisis Intervention component of ESP services, ESP services need to demonstrate compliance with the core competencies articulated above for all aspects of ESP service delivery, as they apply to providing crisis behavioral health services to youth and their families, particularly the following:
- Comprehension of grief and trauma in children and adolescents
- Diagnostic accuracy in the assessment of children and adolescents
- Awareness of the differences in manifestation of mental health and substance use conditions in children versus adolescents, versus adults
- Risk assessment and management skills in working with children, adolescents, and families
- Client engagement and de-escalation skills with children, adolescents, and their families
- Competency in crisis theory and in the use of interventions with children, adolescents, and families that are compatible with principles or resiliency and recovery and likely to stimulate self-help including techniques utilized in:
    - Solution-Focused Therapy
    - Cognitive Behavioral Therapy
    - Stages of Change
    - Motivational Interviewing
    - Shared Decision-making
- Demonstrated broad knowledge of the community behavioral health system for children, adolescents, and families including Child Behavioral Health Initiative (CBHI) services.
- Demonstrate strategic initiatives to strengthen collaboration with local CBHI providers.
- Coordinate all behavioral health crisis response with the youth's existing providers, including Intensive Care Coordination (ICC), In-Home Therapy (IHT) and outpatient providers, other care management programs and primary care provider (PCP/PCC).

Additionally, with regards to providing Mobile Crisis Intervention component of ESP services, ESP programs need to demonstrate the ability to adhere to and demonstrate the following core competencies:

Agency/programmatic competencies

- Documented understanding of Crisis Theory, Recovery-Oriented Care, Wraparound planning process, and Systems of Care principles and philosophy at all levels of the organization's management, and preferably experience in the implementation of these approaches
- Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels, in providing behavioral health services to children, adolescents, and their families
- Documented experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis intervention, and/or treatment services;

administrative infrastructure that supports the delivery of Mobile Crisis Intervention 24/7/365, including access to consultation with a child-trained supervisor and board-certified or eligible psychiatrist
- Ability to integrate youth and family voice in organization governance
- Solicits and values the youth's view of the crisis situation and possible solutions
- Competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services
- Articulation and adherence to a program philosophy that:
    - Values a young person's return to natural environment
    - Expects client's return to higher level of functioning
    - Instills client/family with hope for the future
    - Expects improvement by the end of intervention
- Outcomes data, quality improvement processes, and satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families
- Relationships with child- and family-focused community resources in the service area, including but not limited to, child-serving state agencies and social service providers, schools, residential programs, family and youth organizations, pediatric primary care providers, and ability to coordinate care and treatment across providers and service agencies
- Membership in child advocacy and/or child-focused trade organizations

Clinical competencies

- Comprehension of family dynamics and ability to engage caregivers as partners in finding solutions
- Comprehension of normal child development
    - Developmental milestones
    - Cognitive development
    - Identity development
    - Physical development
- Adherence to Wraparound philosophies[1]
    - Family voice and choice
    - Team-based (includes child and family)
    - Use of natural supports
    - Collaboration
    - Community-based
    - Culturally competent
    - Individualized
    - Strengths-based

[1] Source: Eric J. Bruns, Janet S. Walker, Jane Adams, Pat Miles, Trina Osher, Jim Rast, and John VanDenBerg, (2004). *The Ten Principles of Wraparound*

- Persistence
- Outcomes-based

Providers are expected to demonstrate a commitment to best practice principles as outline in the documents below:

MCI Practice Guidelines are located http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/cbhi-resources-for-providers.html

Crisis planning tool companion guide is located http://www.masspartnership.com/provider/CrisisPlanning.aspx

III. ESP Structure

The structure of the Emergency Services Program system includes locally based ESPs supported by statewide functions that contribute to programmatic improvements and system efficiencies.

A. Local ESP Structure

Each locally based ESP shall be a comprehensive, integrated program of crisis behavioral health services, including services delivered through the ESP's mobile crisis intervention services for adults and children, in the ESP's accessible community-based location, and in the ESP's adult Community Crisis Stabilization (CCS) program. Each of these service components are described further in the section below. The selected ESP providers shall be expected to envision their programs, inclusive of all these service components, as one integrated emergency services program. They shall be expected to use their staffing resources in an integrated and flexible manner, using all available resources to respond to the needs of individuals who require their services on a daily basis, with fluctuations in volume, location of services, etc. The ESP structure includes staffing infrastructure to provide ESP specific management, clinical supervision, and direct services in proportion to the projected volume beginning in FY16 for each catchment area.

It is also expected that ESP programs shall have resources to support the management and delivery of ESP services, such as administrative and financial oversight, medical leadership, and technology infrastructure. Please reference Appendix IV for an example staffing pattern for an average size ESP.

B. Catchment Areas

Appendix I: ESP Catchment Areas lists the cities and towns to be included in each of the four Southeast ESP catchment areas as of July 1, 2015. A total of five local ESPs shall deliver ESP services in the Southeast region of the Commonwealth. Four of the five ESPs (formerly DMH operated) are included in this RFR and listed in Appendix I. One local ESP shall cover each of 4 catchment areas that were formerly DMH operated (The fifth ESP is currently managed by MBHP).

C. System Level Structure

1. Contract management

MBHP is responsible for contract management, financial management, and claims payment, as well as the consistency and quality of ESP services. Integral to ensuring consistency and quality of care, MBHP works with providers to develop statewide universal competencies for all ESP programs and ESP clinicians, which are to be integrated into the ongoing evaluation of each ESP.

Performance measurement

MBHP measures the performance of ESP contracts through a variety of quantitative and qualitative indicators. In collaboration with the Department of Mental Health (DMH) and MassHealth Office of Behavioral Health, MBHP has established Quality Indicators to measure the ESP provider requirements delineated in the General Performance Specifications, the ESP Performance Specifications, the Mobile Crisis Intervention Performance Specifications, and the Adult Community Crisis Stabilization Performance Specifications, all of which are included in the Appendices to this document. Please reference Appendix II for ESP Performance Specifications and Appendix III for a breakdown of ESP/MCI Quality Indicators.

The **Quality Indicators** include:

- Intervention Location
- Disposition
- Response Time in Minutes
- Response Time Percent within 60 minutes

Additional quality measures may include but are not limited to:

- Delivery of a comprehensive crisis service that minimally includes crisis assessment, intervention, and stabilization
- Clinical appropriateness of disposition, including use of diversionary services when clinically indicated
- Compliance with standards of care
- Satisfaction survey data
- Identifying and implementing quality improvement initiatives

MBHP will monitor and manage the performance of ESP services across all ESPs utilizing data on the following levels: provider, regional, and statewide. MBHP will monitor and manage the performance of each ESP through regular reporting requirements and in-person network management meetings.

ESPs shall be expected to comply with all reporting requirements of MBHP, as well as those of MassHealth.

Accountability to MassHealth-contracted Managed Care Entities (MCEs)

It is important to note that ESPs will also be accountable to other payers with whom they contract, including the MassHealth MCEs. This accountability will include, but not be limited to, the clinical care of their members, compliance with authorization procedures, and all other applicable requirements of the MCE, including information reporting requirements.

2. Statewide function

The local ESPs are further supported by the following statewide function. The ESPs are expected to use this resource in their daily service to individuals and families statewide, as required in Appendix II: ESP Performance Specifications.

- *Massachusetts Behavioral Health Access (MABHA) website:* ESPs shall use MABHA to enable ESP clinicians to locate potential openings in mental health and substance use services for the purpose of referring individuals to those available services.
- The ESP is required to update the MABHA website a minimum of once per 8 hour shift, every day with current Community Crisis Stabilization bed availability.

3. Staff Compensation

For each position in which a private contractor will employ any person where the duties of the position are substantially similar to the duties currently performed by a regular DMH employee, the private contractor must pay at least a minimum wage rate equal to the lesser of:

1) Step one of the grade or classification under which the comparable regular agency employee is paid, or
2) The average private sector wage rate for said position as determined by the executive office for administration and finance from data collected by the division of employment and training and the division of purchased services.

The minimum wage rates associated with ESP Core Staffing positions that are substantially similar to duties currently performed by DMH employees are summarized in Appendix V.

D. Program Model Overview

1. Emergency Services Program (ESP)

Description

MBHP will contract with one locally based provider to administer the ESP for each catchment area. Each ESP shall be a comprehensive, integrated program of crisis behavioral health services, including services delivered in the community through the ESP's mobile crisis intervention services for adults and youth, in the ESP's accessible community-based location, and in the ESP's adult CCS. The ESP shall provide crisis behavioral health services including but not limited to, the core clinical services of a behavioral health crisis assessment, intervention, and stabilization to all individuals, within the defined population scope, who access ESP services through any and all of these service components. Each of these service components are described below. The consistent availability of these service components across all ESPs statewide is necessary in order to ensure consistency in the type and quality of these services in all catchment areas and to serve as the basis for educating the public about the availability of these services and facilitating access to them.

Local variation

While every ESP across the Commonwealth shall offer all of these service components, there will be some variation among ESPs, so as to be responsive to differences in local needs and resources. For example, while access to crisis behavioral health services shall be provided on a 24/7/365 basis in all catchment areas through one or more service components, the operating hours of the ESPs' community-based locations may vary, in part as dictated by volume in a particular catchment area. Additionally, the ESPs' responses to the needs of special populations may vary, based on local population characteristics and related community resources. Finally,

there may be variance in the service components that the ESP provider will operate directly and those that the ESP provider may subcontract to another provider.

Access

All ESP services in a given catchment area shall be accessed through a toll free number operated by the contracted ESP provider 24/7/365. The ESP shall triage calls to its most appropriate ESP service component, the one that shall provide crisis behavioral health services to the individual in the least restrictive setting, ensuring safety and responsiveness to consumer and family choice.

Integration

ESP providers shall be expected to envision and manage their programs, inclusive of all service components, as one integrated emergency services program responsible for meeting the crisis behavioral health needs of the populations identified in this document, throughout their catchment areas, 24 hours per day, 7 days per week, 365 days per year. The overall ESP program should operate in a fashion that ensures fluidity among its service components and minimizes transitions and inconvenience to individuals in crisis. With the use of flexible, cross-trained staff and cross-scheduling, programs should demonstrate the ability to respond to varying levels of demand in ESP site-based crisis intervention services, mobile crisis intervention services, and CCS services.

It is important to note that the ESP's adult CCS shall be required to be co-located with the ESP community-based location, preferably upon initiation of the ESP contract, or within three months. co-locating ESP services with other services that may be helpful to individuals who utilize ESP services, such as outpatient and diversionary services, operated by their organizations and/or other provider agencies is also encouraged, but not mandatory.

Management functions

The contracted ESP provider shall conduct all clinical, medical, quality, administrative, and financial oversight functions across all the services provided by the ESP and all locations in which these services are provided, including any ESP services provided by subcontractors. More specifically, management functions shall include:

- Staff recruitment, hiring, training, supervision, and evaluation
- Triage
- Clinical and medical oversight
- Quality management/risk management
- Information technology, data management, and reporting
- Claims and encounter form submission
- Oversight of subcontracts
- Interface with payers including the MassHealth-contracted Managed Care Entities (MCEs)
- Interface with MBHP for contract management purposes
- Member and Stakeholder Satisfaction Surveys

Safety

Safety is integral to all ESP services, functions, and operations. Assessing and mitigating risk for individuals who participate in ESP services, as well as for staff who provide them, is a priority. In fact, safety in the workplace is both a need and responsibility of employers in any profession or work setting, for their employees, their customers, visitors, and others who enter that workplace. The ESP model includes various resources and strategies toward this end. Offering various venues for services is one tool, as well as acknowledging that some individuals will continue to require the medical services of a hospital ED setting. Technology resources, including cell phones with GPS and laptops, have been included as operating expenses in the ESP rates. Staffing infrastructure, including bachelor's level staff, Certified Peer Specialists, and Family Partners have been included in the staffing pattern to provide support and comfort to consumers and families, as well as to be available to provide a two-person response, along with a master's level clinician, to many requests for mobile crisis intervention services. Additionally, specific "safety" staffing has been included in the staffing pattern for the ESP community-based locations, to be utilized by ESPs in a manner that helps to promote a calm and safe environment, mitigate risk, and facilitate safety in these settings. ESPs may choose to use these positions in a variety of ways that contributes to a safe environment. In part, this staffing will enable providers to ensure that at least two staff members are present in their community-based locations during at least high-volume operating hours. Finally, various training for all staff will be important to mitigating and managing risk, and sound triage protocols are important in enabling ESPs to make clinical decisions about the services each individual needs, the venue in which they are provided, and the staffing that can best provide them in both a clinically appropriate and safe manner.

Staffing

The ESP structure includes staffing infrastructure to provide ESP-specific management, clinical supervision, and direct services beginning in FY16 for each catchment area. ESPs shall be expected to use their staffing resources in an integrated and flexible manner, utilizing all available resources to respond to the needs of individuals who require their services on a daily basis, while accommodating the specific needs of individuals and families, fluctuations in volume, location of services, etc.

It is also expected that providers shall have resources to bring to bear on the management and delivery of ESP services, such as administrative and financial oversight, medical leadership, and technology infrastructure, and support for such overhead and has been included in the rate. Staffing of each Emergency Services Program shall include the positions listed in Appendix II, Emergency Services Program – Staffing.

2. ESP Community-based Location

Description

The ESP's community-based location is the 24/7/365 "hub" of the emergency services program in each catchment area. The primary purposes of the ESP's community-based location are to:

- Coordinate the operation of, and access to, all the service components of the ESP
- Directly deliver its core service of crisis assessment, intervention, and stabilization at the ESP
- Provide a Community-based location as an alternative to hospital emergency departments (EDs) for individuals seeking behavioral health services when use of the ED may be avoided, such as when there is not a physical condition requiring medical assessment and intervention.

ESPs with contracts in more than one catchment area, might realize operational efficiencies such as centralized call/triage centers, training tools etc.

The ESP community-based location is thereby a primary venue, in addition to mobile crisis intervention services, through which the ESP provides community-based access to crisis behavioral health services. Ensuring that every ESP has a robust community-based location for these stated purposes represents a significant system enhancement. ESPs must have protocols to guide the decision making process regarding the location of intervention.

Expected outcomes from the ESP community-based location include the diversion of unnecessary volume from hospital EDs and increased consumer, family, and community satisfaction with access to crisis services in this less restrictive, community-based setting. ESPs encourage early crisis intervention in order to prevent the development of symptoms that may require hospital-based interventions. The ESP community-based location shall provide a setting that is more conducive than a busy hospital ED to the ESPs utilizing their focused expertise, rapid service initiation, skill in crisis intervention, knowledge of community resources, ability to access ongoing treatment and to offer brief follow-up treatment, and ability to offer flexibility in service duration. ESPs offer a front door into crisis services with the opportunity to be referred up to hospital-based care when indicated.

The ESP shall perform the following functions at, or dispatched from, their community-based location. Any variance will need to be justified by the provider based on local needs and resources.

- Operate a toll free number on a 24/7/365 basis that shall:
  - Triage all requests for crisis services
  - Dispatch adult and Mobile Crisis Intervention services and maintain communication with individuals, families, and such other referral sources as hospital EDs to keep them informed of the expected arrival time of these services
  - Access MABHA when seeking available resources for CBHI or 24 hour levels of care. to MABHA,
  - Provide ESP services on-site at the community-based location for a minimum of 12 hours per day on weekdays and eight (8) hours per day on weekends. Recommended minimum hours are 7 a.m. to 11 p.m. weekdays and 11 a.m. to 7 p.m. weekends. (Note that ESPs shall operate Child and Adult Mobile Crisis Intervention services and the adult CCS 24/7/365, with the latter being co-located with the ESP community-based location at the initiation of the ESP contract or within six months thereof.)

The ESP community-based location shall offer an environment that encourages individuals and families to seek crisis services in this less restrictive, community-based setting. The physical environment and interpersonal climate shall be one that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support. Concurrently, the environment needs to communicate that this is a setting to receive help for crisis behavioral health needs rather than for routine services or general support and socialization.

The ESP provider must directly operate the ESP's community-based location. The ESP's community-based location must be an easy-to-find, centrally located physical site in a population center within the catchment area in which the provider is bidding. The site must be accessible to persons relying on public transportation. .

Also included in the ESP program model and rates are some operating expenses that will facilitate successful delivery of clinical services at the community-based location and support consumers' ability to remain in the community while receiving medically necessary services. As reported by numerous stakeholders, it is often seemingly small details such as food and transportation that can make the difference in the attempt to support consumers through the ESP process and enable them to remain in the community. Modest levels of operating expenses that have been built into the ESP rates include food that will allow the ESP to provide comfort and nourishment to consumers and family members while receiving services; pharmacy, given that ESPs are often faced with needing to spend a small amount of money on a pharmacy co-pay to help a consumer obtain his/her medication and successfully participate in a community-based level of care; and transportation for situations in which the ESP may need to facilitate transportation for a consumer to a pharmacy to obtain medications or to a community- based disposition, such as an outpatient appointment. Thus, these operating expenses are meant to facilitate access to care and increase the feasibility of diversions and community-based services.

Concurrently, ESPs shall be expected to access other resources available to them and the individuals they serve, such as assisting them to arrange MassHealth transportation benefits, to provide or pay for these resources whenever possible.

3. Mobile Crisis Intervention Services (MCI)

Description

MCI shall be integrated into the ESP's infrastructure, services, policies and procedures, staff supervision and training, and community linkages. All ESP services for MassHealth-enrolled and uninsured children and adolescents shall be provided through the ESP's Mobile Crisis Intervention services and staff

Mobile crisis intervention services are an integral part of a comprehensive behavioral health crisis services continuum and a key strategy in reducing the use of unnecessary hospital emergency department (ED) and inpatient psychiatric services.

For children and adolescents, the best practice for delivering crisis services is via discreet and minimally disruptive mobile response to a natural setting such as the child's home or school, or a neutral community-based site. The delivery of strengths-based and solution-focused intervention is aimed at resolution of the crisis, mobilization of natural supports, and rapid linkage to the right level of care. Mobile Crisis Intervention delivers services that are consultative and collaborative, placing a high value on achieving a least restrictive, consensus disposition while ensuring access to medically necessary services

The services are provided in the home, school, or other community-based location and are consensual in nature. Delivery of services in the home or school allows the service provider to take into consideration observations about the environment, gain understanding of culture, interact with family members or other supports, and identify risks. The expectation by service recipients, family members, and care providers – including those in residential facilities, schools, nursing homes, group homes, and shelters – that hospitalization or other placement will result from the intervention is lowered. When mobile crisis intervention services are delivered in schools, residential facilities, nursing homes, group homes, and shelters, mobile crisis professionals have the opportunity to interact with, and educate colleagues about, the system, commitment guidelines, risk management/safety planning, and risk assessment and reduction – interactions that can have positive impact well-beyond the immediate situation.. Mobile crisis intervention professionals are well poised to serve as advocates, educators, system ambassadors and mediators, consultants, and coordinators of care. While mobile care is generally the optimal service delivery option, mobile crisis professionals and teams, guided by ESP developed policies and procedures, retain discretion in choosing whether to begin or continue a mobile intervention based on identified risk factors. Safety of service providers (whether delivering mobile or site-based services) is a first priority, and this factor should be integrated in all aspects of operating a mobile crisis team, including but not limited to, guidelines in driving, navigating, use of maps, cell phones, GPS devices, environmental scanning, ensuring personal safety, identifying exceptions to mobile response, and involving law enforcement agencies. Though not acceptable as a standard method of response, there are times when first response by law enforcement, or co-response by law enforcement and the mobile crisis professional/team, are indicated, and ESPs are strongly encouraged to affiliate with law enforcement agencies to develop these response protocols.

Mobile Crisis Intervention services provide a short-term service that is a mobile, on-site, face-to- face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, seven days a week, 365 days a year. The service includes an intervention that may be up to seven (7) days duration encompassing:

- A crisis assessment, including:
  - Conducting a mental status exam
  - Assessing crisis precipitants, including psychiatric, educational, social, familial, legal/court related, and environmental factors that may have contributed to the current

crisis (e.g., new school, home, or caregiver; exposure to domestic or community violence; death of friend or relative; or recent change in medication)
  - Assessing the youth's behavior and the responses of parent/guardian/caregiver(s) and others to the youth's behavior
  - Assessing parent/guardian/caregiver strengths and resources to identify how such strengths and resources impact their ability to care for the youth's behavioral health needs
  - Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care
  - Assessing medication compliance and/or past medication trials
  - Assessing safety/risk issues for the youth and parent/guardian/caregiver(s)
  - Taking a medical history/screening for medical issues
  - Assessing current functioning at home, school, and in the community
  - Identifying current providers, including state agency involvement
  - Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the youth and parent/guardian/caregiver(s)
  - Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support
  - Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face or by phone from an on-call child psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist

Introduction of Crisis Planning Tools, and assistance in the developing a plan if the youth/family does not already have one , including the elements delineated in the Mobile Crisis Intervention Performance Specifications located in Appendix II. Also see: Crisis Planning Tools: Companion Guide for Providers located at http://www.masspartnership.com/provider/CrisisPlanning.aspx

- Crisis intervention, including
  - Solution-focused crisis counseling
  - Brief interventions that address behavior and safety
- Continued delivery of crisis treatment, stabilization and support services for a period of up to 7 days from the initiation of the crisis service, during which time the ESP shall provide follow up services as indicated, including on-site face-to-face therapeutic services, psychiatric consultation, urgent psychopharmacology intervention, and/or collateral consultation
- Referrals and linkages to family's preferred, chosen and medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care and the Children's Behavioral Health Initiative (CBHI) services.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff shall coordinate with the youth's ICC care coordinator throughout the delivery of the service Mobile Crisis Intervention also shall coordinate with the youth's primary care physician, any

other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

The primary objectives of Mobile Crisis Intervention services are as follows:

- Early intervention in behavioral health crises with family preservation and community-tenure serving as highly valued priorities
- Delivery of a comprehensive crisis service focused on the child and family that includes a crisis assessment, a course of intervention, stabilization of crisis, creation of a risk management/safety plan, and linkage as needed to other services
- Referral to least restrictive and least intensive treatment services consistent with medical necessity and personal and community safety, that serve to divert unnecessary deep-end services or interventions such as inpatient hospitalization, as well as residential treatment services or detention to the extent that utilization results from the youth's behavioral health condition
- Connection and coordination of care for children and their families who qualify for CBHI services
- Ensuring family connection with the services, which are chosen with the family to meet the child's and family's needs, that will promote recovery, family skill-building, and natural family and community support
- Provision of a brief period (up to 7 days) of follow-up treatment services and supports to ensure crisis resolution and effective connection to ongoing, medically necessary services

Effective Mobile Crisis Intervention shall produce the following outcomes:

- Increased confidence by child and family in crisis self-management
- Increased use of natural supports
- Timely and increased connections to community services
- Timely follow-up with child's treatment service
- Decreased use of hospital emergency departments (EDs)
- Reduced use of inpatient psychiatric services

Effective Mobile Crisis Intervention may also contribute to the following additional outcomes, to the extent the use of these resources may result from a youth's behavioral health condition:

- Reduced referrals into residential treatment
- Juvenile court/DCF diversions
- Fewer days out of the home

ESP services for children and adolescents shall be provided by the ESP's Mobile Crisis Intervention services in the community as described above unless the child, parent, or caretaker prefers to receive these services in another setting such as the community-based location. Or, the
ESP may assess that there is a clinical or safety need that contraindicates providing services in the home and indicates the need to use the ESP's community-based location or other setting for a given child or adolescent. Crisis assessments for youth only occur in a hospital emergency

department (ED) if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuse required consent for service in the home or alternative community settings; or if the request for Mobile Crisis Intervention services originates from a hospital ED. In those instances in which a youth is brought or sent to a hospital ED before the ESP is called or as determined by the ESP during the triage call, or because the parent or child chooses to go to the ED at any time they believe that the child requires services to treat an Emergency Medical Condition, the Mobile Crisis Intervention staff mobilizes to the ED. The number of hospital-based interventions will be closely monitored to ensure that mobile crisis intervention services are delivered primarily in community settings.

Staffing

Mobile Crisis Intervention service shall be overseen and supported by the ESP staff who relate to all ESP service components. Please reference Appendix II, Mobile Crisis Intervention- Staffing for a list of required staff and credentials.

"Emergency Services Program: Staffing." This service component shall be further supported by a dedicated program manager who shall be responsible for managing the Mobile Crisis Intervention service in compliance the MCI Performance Specifications. This service shall be further staffed by child-trained clinicians and paraprofessionals who will work in a braided fashion to ensure crisis resolution and successful linkage. Paraprofessionals who are part of the teamed response to youth and families are shall generally meet the definition of and be trained as Family Partners, who have lived experience as a primary caretaker of a child with Serious Emotional Disturbance. ESPs shall be expected to ensure that at least one of their Bachelor's level staff members are in fact Family Partners. Regardless, the role of the second person on the team is to pay attention to and support the specific experience of the parent(s) whose child is in the midst of a serious health event.

4. Runaway Assistance Program

Description

As a component of the Mobile Crisis Intervention program, providers shall be responsible for the provision of Runaway Assistance in the community 24/7/365 to youth between the ages of 6 to 18. The ESP/MCI Provider shall establish a Mobile Crisis Intervention/Runaway Assistance Program ("MCI/RAP") to provide a temporary and safe place for youth to stay on a voluntary basis, until such youth is transferred to another appropriate service provider.

The primary tasks of the RAP Provider are as follows:

- Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.
- Maintain an MCI/RAP site where police can bring youth during non-court hours.
- Greet police officers and youth who come to the MCRI/RAP site during non-court hours;
- Supervision at least a one-to-one basis until the youth:
  - Is transferred to a hospital level of care
  - Is transferred to the care of ALP staff, or

  - Voluntarily leaves the site
- If a youth who is brought to the MCI/RAP site chooses to voluntarily leave:
  - Immediately notify the police department of the city or town where the MCI/RAP site is located and the DCF (if the youth is known to be in DCF custody);
  - Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123 §12, and, if determined appropriate, apply for hospitalization, and
  - Submit a critical incident report form to MBHP
- Designate a manager to oversee the MCI/RAP

The MCI/RAP manager designated by the ESP/MCI shall oversee the MCI/RAP and shall also:

- Ensure the MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court ours and be available to MCI/RAP staff for consultation
- Provide back-up coverage for on-call MCI/RAP staff
- Train program staff regarding MCI/RAP procedures
- Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP, and
- On the business day following the arrival or transfer of a youth, follow up with the police department, and follow-up with any ALP to which the youth was transferred

The ESP/MCI shall provide quarterly and annual reports to MBHP in a form designated by MBHP on outcomes and outputs related to the MCI/RAP, including, but not limited to:

- The number of youth who receive a crisis intervention assessment
- Demographics related to youth served including, but not limited to, age, gender, ethnicity and city/town of residence
- The number of youth unable to be maintained safely at the MCI/RAP site and who require further assessment in the secure environment of the emergency department
- The number of youth transferred to the care of ALP staff, and
- The number of youth who voluntarily leave the MCI/RAP site

5. Adult Mobile Crisis Intervention

Description

The Emergency Services Program (ESP) provides crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year (24/7/365) to Members of all ages who are experiencing a behavioral health crisis. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows a Member to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with a Member in crisis, the ESP provides a core service including crisis assessment, intervention, and stabilization. In doing so, the ESP conducts a crisis behavioral health assessment and offers short-term crisis counseling that includes active listening and support. The ESP provides solution-focused and strengths-oriented crisis intervention aimed at working with the Member and his/her family and/or other natural supports to understand the current

crisis, identify solutions, and access resources and services for comfort, support, assistance, and treatment. The ESP arranges the behavioral health services that the Member selects to further treat his/her behavioral health condition based on the assessment completed and the Member's demonstrated medical need. The ESP coordinates with other involved service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. The ESP also provides the Member and his/her family with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community. While it is expected that all ESP encounters minimally include the three basic components of crisis assessment, intervention, and stabilization, crisis services require flexibility in the focus and duration of the initial intervention, the Member's participation in the treatment, and the number and type of follow-up services.

ESP services are directly accessible to Members who seek behavioral health services on their own and/or who may be referred by any other individual or resource, such as family members, guardians, community-based agencies, service providers, primary care physicians, residential programs, schools, state agency personnel, law enforcement, courts, etc. ESP services are community-based in order to bring treatment to Members in crisis, allow for Member choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery. Local ESPs provide crisis behavioral health services in the community, through mobile crisis intervention services, accessible community-based locations, and Community Crisis Stabilization (CCS) programs.

All ESPs shall provide Adult Mobile Crisis Intervention services to any community-based location, including private homes, from 7 a.m. to 8 p.m. Outside of those hours, Adult Mobile Crisis Intervention services shall be provided in residential programs and hospital EDs. ESP performance will be measured against established targets for the percentage of services that are provided on a "mobile" basis, exclusive of hospital EDs.

6. Adult Community Crisis Stabilization (CCS)

Description

The adult (ages 18 and over) Community Crisis Stabilization (CCS) program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18-20 under the Children's Behavioral Health Initiative (CBHI). CCS provides a distinct level of care where primary objectives of active multi-disciplinary treatment include: restoration of functioning; strengthening the resources and capacities of the Member, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized crisis prevention plan and/or safety plan, as part of the Crisis Planning Tools for youth; and linkage to ongoing, medically necessary treatment and support services. CCS staff provides continuous observation of, and support to, Members with mental health or co-occurring mental health/substance use

disorder conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care include: crisis stabilization; initial and continuing bio-psychosocial assessment; care coordination; psychiatric evaluation and medication management; peer support and/or other recovery-oriented services; and mobilization of family and natural supports and community resources. CCS services are short-term, providing 23-hour observation and supervision, and continual re-evaluation.

CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery. CCS staff provides psycho-education, including information about recovery, wellness, crisis self-management, and how to access wellness and recovery services available in the Member's specific community. Guided by the treatment preferences of the Member, CCS staff actively involves family and other natural supports at a frequency based on Member needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. For young adults who are involved with, or who are referred for, CBHI services – including Intensive Care Coordination (ICC) – with Member consent CCS staff provides treatment recommendations and participates in team meetings, as appropriate.

CCS shall be primarily used as a diversion from an inpatient level of care; however, the service may be used secondarily as a transition from inpatient services, if there is enough service capacity and the admission criteria are met. Admissions to the CCS shall occur 24/7/365 based on determinations made by mobile and site-based ESP staff. Discharges from the CCS shall occur 24/7/365, and discharge processes shall include efficiencies that maximize service capacity. Readiness for discharge shall be minimally evaluated on a daily basis, and the length of stay is expected to be very brief.

Minimum Capacity

The allocations of CCS capacity identified in Appendix I: ESP Catchment Areas, should be considered a minimum number that can be adequately supported by the core staffing pattern reflected and described under "staffing" below. Each catchment area must have a minimum number of CCS beds available as follows:

Brockton – 6
Cape and Islands – 6
Fall River – 5
Taunton/Attleboro – 7

Adult CCS program utilization will be monitored by MBHP to ensure adherence to the performance specifications for this service (Appendix II), the goals of the ESP system, and relevant performance indicators including by not limited to daily reporting of CCS capacity on Massachusetts Behavioral Health Access (MABHA) website.at least once per shift, (3x daily) every day.

Location of adult CCS

The ESP's adult CCS is required to be co-located with the ESP community-based location. Preferably upon initiation of the ESP contract, or within the first three months thereof. If a provider is awarded a contract with this contingency and fails to meet the full set of criteria within three months, the provider may be at risk of termination of the contract.

Collaboration between ESP and adult CCS

The co-location of the adult CCS and the ESP's community-based location shall enhance service continuity and increase administrative efficiency to benefit those served. The overall ESP program shall operate in a fashion that ensures fluidity among ESP mobile services, site-based crisis services at the ESP community-based location and the CCS and minimizes inconvenience to individuals in crisis. With the use of fluidly trained staff and cross-scheduling, ESPs shall demonstrate the ability to respond to varying levels of demand in these three service components. All staff members are expected to share expertise in terms of clinical knowledge, service delivery (as appropriate for each discipline), and discharge planning.

Staffing

Community Crisis Stabilization (CCS) service shall be overseen and supported by the ESP staff who relate to all ESP service components, as listed in Appendix II, Emergency Services Program-Staffing. The CCS is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year. CCS provides awake staffing 24/7/365. CCS utilizes a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use disorder conditions in adults. The ESP/MCI ensures that all staff receive ongoing supervision appropriate to their discipline and level of training and licensure, and in compliance with MBHP's credentialing criteria. For CPSs and Family Partners, this supervision includes peer supervision.

Please reference Appendix II, Adult Community Crisis Stabilization – Staffing, for additional staffing requirements.

E. Linkages

The ESP has a clear command of the local community crisis continuum - the strengths and limitations, resources, barriers, and practice patterns – and, in collaboration with MBHP, initiates strategies aimed at strengthening service pathways and the safety net of resources. ESP staff is knowledgeable of available community mental health and substance use disorder services within their ESP catchment area and statewide as needed, including the MBHP levels of care and their admission criteria, as well as relevant laws and regulations. They also have knowledge of other medical, legal, emergency, and community services available to the Member and their families, including recovery-oriented and consumer-operated resources and resources.

The ESP also communicates, consults, collaborates, refers to, and ensures continuity of care with many other resources involved with utilizers of ESP services including, but not limited to, the following:

- Primary care services and hospitals
- State agencies
- Schools
- Residential programs
- Law enforcement entities

The ESP develops and maintains close working relationships with recovery-oriented and consumer-operated resources in its local community, including but not limited to Recovery Learning Communities (RLCs), Clubhouses, and AA/NA. The ESP develops specific linkages with the RLCs relative to warmline services, if offered by their local RLC. These working relationships are expected to be with recovery-oriented and consumer-operated organizations that support not only adults but youth and families as well.

With Member consent, the ESP collaborates with the Member's PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications.

The ESP develops and maintains relationships with the hospitals in its catchment areas characterized by ongoing and consistent communication, problem solving, planning and innovation. The ESP works with the ED to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services, as well as how to best care for Members who present for services in both the ED and ESP settings. The ESP negotiates roles with the ED, develops contingency plans for fluctuations in utilization, and creatively uses hospital and community resources to meet the needs of its communities. The ESPs/MCIs are required to collaborate with the ED to ensure that proper documentation of any intervention within the ED is appropriately shared with that facility.

Other linkages with behavioral health continuum for youth:
The ESP develops and maintains linkages relevant to services for children, adolescents, and families, as required in the MCI performance specifications. This knowledge includes ESP staff being fully aware of, and knowing how to access, CBHI services.

When serving a youth (up to age 21) who is receiving ICC or In-Home Therapy Services, ESP staff shall work closely with the youth's care coordinator or therapist throughout the delivery of the service.

- ESP staff shall readily identify youth up to the age of 21 with MassHealth Standard or
- CommonHealth who are involved in multiple services systems or otherwise appear to demonstrate a medical need for one or more CBHI services.

- ESP staff, with informed consent, shall connect children and families to mutually agreed-upon CBHI services. If it appears that more than one service may be useful to the family, ESP staff shall connect the family to the CSA so that a plan of service can be developed.
    - ESP staff shall support linkages with the family's natural support system, including friends, family, faith community, cultural communities, and self-help groups (e.g., Parental Stress Line, AA, PAL, etc.).

Other linkages

ESPs shall disseminate information about community resources that will aid in the amelioration of stressors, including those that offer food, clothing, shelter, utility assistance, homelessness support, supported housing, supported employment, landlord mediation, legal aid, educational resources, parenting resources and supports, etc.

F. Recovery-Oriented Services

Background

ESPs shall deliver services in a manner that is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) consensus statement on mental health recovery,[2] which states:

> *"Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, as the 'single most important goal' for the mental health service delivery system."*
>
> *"To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. Over expert panelists participated, including mental health consumers, family members, providers, advocates researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels."*

The following consensus statement was derived from expert panelist deliberations on the findings:

[2] U.S. Department Of Health And Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services, www.samhsa.gov

> "*Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."*

The 10 Fundamental Components of Recovery

SAMHSA's consensus statement on mental health recovery identified the following fundamental components of recovery that ESP providers are expected to integrate into their service delivery. It is reproduced here from that document.

Self-direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and person-centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end-result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions – including the allocation of resources – that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner,

caregiver, friend, student, or employee). The process of recovery moves forward through interaction with others in supportive, trust- based relationships.

Peer support: Mutual support – including the sharing of experiential knowledge and skills and social learning – plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers – including protecting their rights and eliminating discrimination and stigma – are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Description

Recovery-oriented values, principles, practices, and services have been integrated into the program model described in this document. To summarize, ESPs shall support resiliency, rehabilitation, and recovery of all individuals to whom they provide emergency behavioral health services, by integrating mental health, substance use, and co-occurring rehabilitation and recovery principles and practices throughout the service delivery model and implementing specific recovery-oriented services, including peer specialist and family support services. All program policies and procedures are designed to promote acceptance of Members into their contracted services within an atmosphere of trust at all levels of motivation and readiness and with any reasonable personal preferences.

All ESPs shall be required to employ one or more Certified Peer Specialists (CPS) to work in the ESPs' community-based locations. Additionally, there is bachelor's level staff in the staffing patterns for the ESPs' Adult Mobile Crisis Intervention services and adult Community Crisis Stabilization programs (CCSs), and ESPs will be encouraged to hire those who are also credentialed as a CPS. As described above, Certified Peer Specialists shall provide support and information to consumers while they are receiving services at the ESP community-based

locations and may assist ESP clinicians in arranging the services needed for individuals after the ESP intervention. In the Adult Mobile Crisis Intervention services, the bachelor's level staff, some of whom shall also be CPSs, shall accompany the master's level clinician on mobile visits. Similarly, the staffing pattern for Mobile Crisis Intervention includes paraprofessional staff, many of whom shall also be Family Partners. ESPs shall be specifically required to hire at least one Family Partner in their Mobile Crisis Intervention program. Family Partners have lived experience as a primary caretaker of a child with Serious Emotional Disturbance. These staff shall provide support to youth during their involvement in the Mobile Crisis Intervention services.

The ESPs shall also develop and maintain close working relationships with local programs that and will complement and integrate their services with the following formal and informal resources and programs:

a. Recovery-oriented and peer-operated services and supports;
b. Wellness programs that promote skill-building, vocational assistance, supported employment, and full competitive employment;
c. Natural community supports for Members and their families;
d. Self-help including Anonymous recovery programs (e.g., 12-step programs) for Members and their families; and
e. Consumer/family/advocacy organizations that provide support, education, and/or advocacy services, such as Parent/Professional Advocacy League (PPAL), the Federation of Children with Special Needs, Recovery Learning Communities (RLCs), Clubhouses, the National Alliance on Mental Illness (NAMI), etc.

G. Services for Special Populations

Background

ESP services must be relevant to the age, level of development, culture, values, beliefs, and norms of all individuals who seek services and their families. Both the content of the assessment and intervention, as well as the manner in which these services are delivered, must be informed by knowledge, respect for, and sensitivity to the individual's clinical and cultural context and provided in his/her preferred language and mode of communication. Ensuring that ESP services are relevant to all populations is a great challenge given the broad range of populations who utilize these services, and doing so involves strategies at both the local and statewide levels of the ESP system.

The ESP ensures that service delivery facilitates communication, access, and an informed clinical approach with special populations including but not limited to:

- Intellectual and developmental disabilities
- Deaf and hard of hearing
- Blind, deaf-blind, and visually impaired
- Culturally and linguistically diverse populations
- Elders
- Veterans

- Homeless
- Gay, lesbian, bisexual, transgendered

The needs of specific or "special" populations may be characterized relative to one of the following, which are not intended to be mutually exclusive:

Communication: Individuals with communication needs will be able to benefit from the core ESP service, but require the facilitation of communication, such as through language interpreters,
American Sign Language interpreters, TTD, or Braille materials.

Access: Some individuals require support, accommodations, assistance, and/or service delivery in a particular venue to gain access to ESP services. Once accessed, these individuals are able to benefit from the core ESP service. Access needs may include specific education and outreach, the availability of mobile evaluations for populations who are unable or reluctant to seek services in the community, transportation, an environment that is welcoming and inclusive, etc. For example, many elders require mobile crisis intervention services provided in their homes, due to their medical conditions and/or difficulty leaving their homes and/or reluctance to use behavioral services, particularly in traditional settings.

Informed clinical approach: For some individuals, an informed clinical approach is needed in the implementation of the core ESP service. ESP clinicians must have understanding and sensitivity to both the unique clinical and cultural context of these populations in conducting the core ESP services of assessment, crisis intervention, and stabilization. This sensitivity means, for example, that in addition to utilizing appropriate means of communication with an individual who is deaf, it is equally important to understand deaf culture and assess the individual in that context.

Unique clinical service: Services to individuals may require the use of specialized assessment tools or techniques that vary substantively from those normally used in providing core ESP services. Examples may include a different approach to clinical engagement, different means of gathering information, and collection of different than usual content that must be included in the assessment to inform the diagnosis and disposition, such as for individuals with intellectual disabilities.

Please note that the following are not identified as "special populations" because these populations represent the majority of individuals who utilize ESP services, and their needs are addressed throughout the program model described in this document. ESPs shall ensure that all ESP clinicians and other staff receive training and meet core clinical competencies in serving the following populations:

- Children, adolescents, and their families
- Adults
- Persons with mental health conditions

- Persons with substance use condition
- Persons with co-occurring mental health and substance use condition

Local ESP response to special populations

The responses to the needs of special populations at a local ESP level shall therefore include:

- *Access*: Each ESP shall be required to articulate and implement specific outreach and other strategies to ensure access to ESP services for each identified special population.
- *Core clinical competency*: In order to provide an informed clinical approach in the crisis assessment and intervention with individuals in each identified special population, each ESP shall be required to ensure that ESP clinicians receive training and meet specified core clinical competencies relative to each.
- *Special services*: All ESPs shall ensure staff training and other mechanisms for providing an ESP service appropriate to individuals with intellectual and developmental disabilities. Some ESPs shall also offer specific services to some other special populations, based on the needs of their local communities and the prevalence of given populations therein. For example, an ESP may develop a mobile crisis intervention team to respond to a certain high incidence culturally or linguistically diverse population in a given area.

Statewide support from state agencies

In order to support ESPs in responding to special populations, DMH, MassHealth, and MBHP will work with state agencies to identify central office and local contacts that can be available to consult with each ESP on available resources and systems issues relative to their constituents. Some state agency staff may also be resources for clinical consultations regarding the populations they serve.

H. Hospital/Medical Interface

ESP working relationships with hospital emergency departments (EDs) in their catchment areas

The working relationship between an ESP and the hospitals in their catchment area, particularly their EDs, is critical to meeting the behavioral health needs in the communities they both serve. ESP relationships with the hospitals in their catchment areas should include ongoing and consistent communication, problem solving, and planning. ESPs and EDs must work together to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services, as well as how to best care for individuals who present for services in both the ED and the ESP settings. ESPs and EDs should negotiate roles, develop contingency plans for fluctuations in utilization, and creatively use hospital and community resources to meet the needs of their communities.

Please see Appendix I: ESP Catchment Areas, which identifies the hospital EDs located in each catchment area. Providers are expected to articulate specific strategies for collaborating with each ED to achieve the goals related to hospital utilization articulated in the section below.

ESPs shall cooperate with hospitals that require ESP clinicians to be credentialed in order to provide crisis behavioral health services in the hospital ED, in compliance with MBHP Network Alert #19 *General Hospitals Credentialing ESPs.*

ESP goals related to hospital utilization

Emergency department (ED) diversion

Subject to applicable state and federal regulations that entitle MassHealth members to seek emergency services for an Emergency Medical Condition, a priority goal of the ESP model is to interrupt patterns of over-reliance on hospital EDs as the first point of contact in the event of a behavioral health crisis. While EDs are an important component of the crisis continuum, most behavioral health crises can be readily and more effectively addressed in the community. Every ESP must be organized around the diversion of behavioral health utilization from those settings when there is not a physical condition or level of acuity that requires medical assessment and intervention, while understanding that MassHealth Members are entitled to seek emergency services in an ED if they believe they have an Emergency Medical Condition. ESPs are expected to develop and implement specific strategies to change referral and utilization patterns in their communities and shift volume from hospital EDs to their community-based services, specifically their child/adolescent and Adult Mobile Crisis Intervention services, their community-based locations, and their adult CCSs. ESPs shall create a service pathway that screens for the need to refer up to a hospital ED rather than step-down from hospital-based emergency care.

Timely response

Another priority goal of the ESP system is to respond to all requests for crisis assessment, intervention, and stabilization in a timely fashion, in order to be responsive to the individual's and/or caretakers' sense of urgency, intervene in behavioral health crises early, and prevent the adverse impact that treatment delay may have on individuals, families, and settings in which those individuals await these services. This goal is particularly important relative to those who await ESP services in the hospital ED setting. Although the ESPs will be working toward the goal of decreasing behavioral health utilization in the ED setting, some individuals are expected to continue to present at EDs if they believe they have an Emergency Medical Condition. It is critical for ESPs to respond quickly to requests for their services in the hospitals EDs in their catchment areas, in order to minimize the duration of individuals' time in this more restrictive setting, thereby contributing to efforts to reduce ED overcrowding and boarding. ESPs shall begin all crisis assessments requested for individuals, within the ESP scope defined in the ESP Performance Specifications, no later than one hour from the time of readiness. Please refer to Appendix II: ESP Performance Specifications and Appendix III: Quality Indicators for more information regarding response time requirements.

ESPs shall be expected to develop specific strategies with EDs in their catchment area to ensure timely access to ESP services for individuals who present in the ED seeking behavioral health

services. ESPs shall negotiate arrangements with each ED, which may include, but not be limited to, ESP clinicians traveling to the ED to provide ESP services within required timeframes; the ESP outposting clinicians at the ED during specified high-volume hours; the ESP subcontracting to the ED for the hospital to directly provide the emergency behavioral health service; and/or other arrangements as identified by the ESP and negotiated with the ED. ESPs shall also educate EDs about other behavioral health services to which individuals may be triaged, such as ATS or urgent outpatient services. When ESPs respond to individuals who have presented in an ED, the ESP shall be required to meet a response time requirement of no longer than one hour, and they shall be responsible for providing the core ESP service of crisis assessment, intervention, and stabilization.

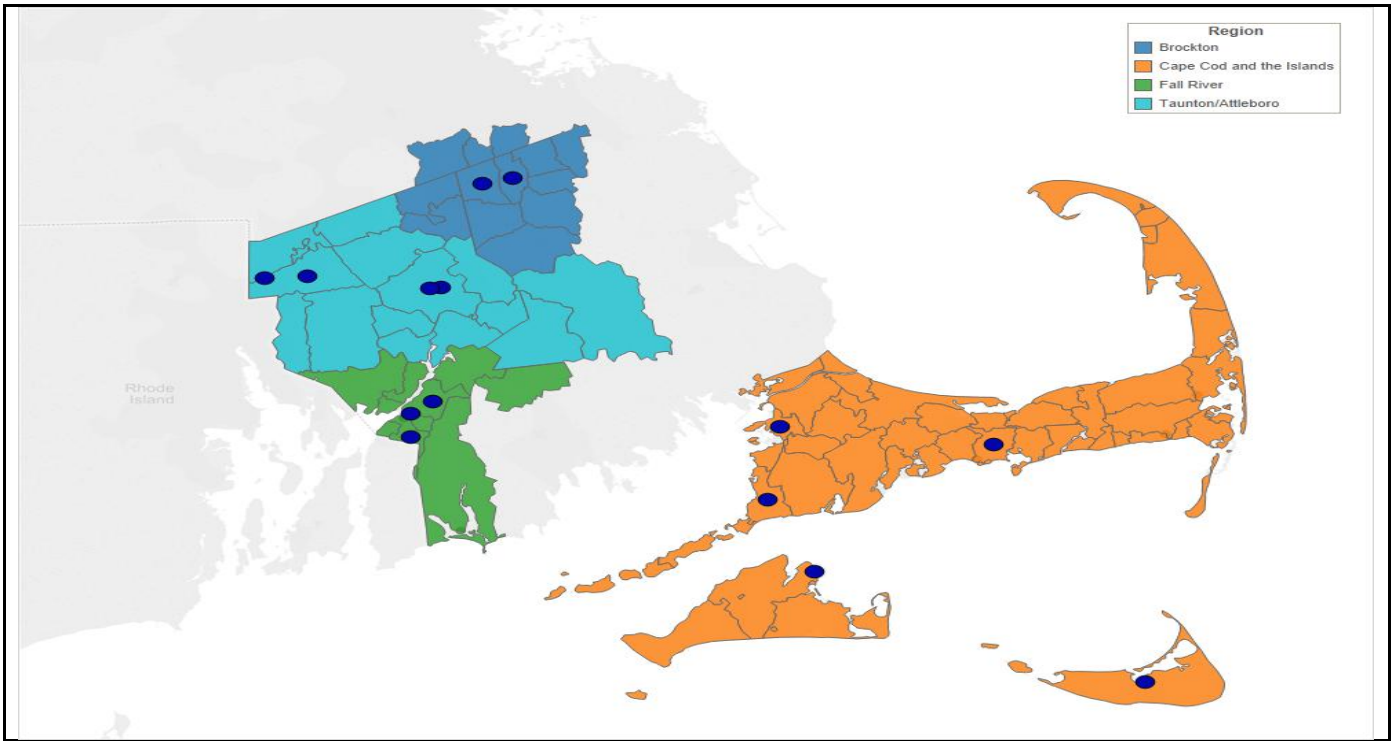
Inpatient diversion

Strategies that reduce unnecessary psychiatric hospitalization help to preserve the availability of this vital community resource in instances when it is needed. Persons who receive behavioral health crisis services in a hospital ED are more likely to be hospitalized than those treated in the community. Providing ESP services in alternative community-based locations will increase the likelihood of referral to appropriate, timely, and least-restrictive ongoing services in lieu of an inpatient psychiatric admission. In addition, ESPs shall be expected to work with EDs to identify and implement additional specific strategies to maximize utilization of community-based diversionary services (including rapid linkage to treatment) in a manner that is consistent with medical necessity criteria. Please refer to Appendix III: Quality Indicators for more information regarding disposition goals.

Medical evaluation

During a behavioral health crisis, a small percentage of individuals require medical evaluation to assess and/or treat a medical condition that may or may not be contributing to their behavioral health condition. Most individuals do not require general medical evaluation, beyond screening, as part of a crisis assessment and intervention. Given that the majority of ESP services shall be provided in the community rather than in hospital EDs, ESPs will be expected to develop protocols and strategies to support ESP staff in screening individuals for the need for medical evaluation, based on the *Medical Clearance Guidelines for Emergency Service Programs (ESP) & Acute Inpatient Facilities: A Consensus Statement* developed by task force members of the Massachusetts College of Emergency Physicians and the Massachusetts Psychiatric Society. ESPs shall refer differentially to hospital EDs and primary care clinicians, within a timeframe that is based on the urgency of that need. It will be important for ESPs to develop and maintain protocols with their local EDs in order to ensure access to medical evaluation for individuals who require this service and have come to the ESP's attention in their community-based location or through their mobile crisis intervention services.

Appendix I: Catchment Areas



	Brockton	Cape Cod and the Islands	Fall River	Taunton/Attleboro
Towns Served	Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Holbrook, Pocasset, Rockland, Stoughton, West Bridgewater, Whitman	Aquinnah, Barnstable, Bourne, Brewster, Chatham, Chilmark, Cotuit, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Gosnold, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Osterville, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Woods Hole, Yarmouth	Assonet, Fall River, Freetown, Somerset, Swansea, Westport	Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleborough, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Taunton
CCS Bed Capacity	6	6	5	7
Hospital EDs **Indicated by blue dots on graph*	Good Samaritan Medical Center, Signature Healthcare Brockton Hospital	Falmouth Hospital, Nantucket Cottage Hospital, Martha's Vineyard Hospital, Cape Cod & Islands Mental Health Center, Cape Cod Hospital	Corrigan Mental Health Center, St. Anne's Hospital, Charlton Memorial Hospital	Sturdy Memorial Hospital, Arbour-Fuller Hospital, Morton Hospital, Taunton State Hospital

Appendix II: Performance Specifications

GENERAL PERFORMANCE SPECIFICATIONS

These General performance specifications apply to all MBHP network providers at all levels of care. Additionally, **providers are held accountable to the service-specific performance specifications for each level of care for which they are contracted.** All performance specifications are located in the performance specifications section of the Provider Manual, found at www.masspartnership.com. The requirements outlined within the service-specific performance specifications take precedence over these General performance specifications.

Philosophy

The MBHP provider network supports Members of all ages and their families living with severe and persistent mental illness, emotional or behavioral issues, substance use disorders, and co-occurring disorders to improve their level of functioning and live successfully in their communities. In doing so, the MBHP provider network offers a broad continuum of care including emergency, inpatient, outpatient, and diversionary services, emphasizing the least restrictive, community-based services available whenever clinically appropriate. Recognizing that behavioral health and medical conditions co-exist, behavioral health providers incorporate both into the assessment and care planning processes and collaborate with medical providers to improve the outcome of the Member's health. Providers of all levels of care must ensure that, in any setting in which behavioral health levels of care or both behavioral health and non-behavioral health levels of care are co-located, all performance specifications are met for the contracted level(s) of care.

All MBHP network providers incorporate wellness, resiliency, and recovery principles and practices into their care approaches and offer recovery-oriented services. Providers are accepting of Members, both initially as well as upon return after any disruption in services, regardless of resources. Providers engage Members in services as they are able to participate. Care focuses on increasing Members' ability to successfully manage their conditions, symptoms and services; build recovery and resilience; and meet their personal goals. Programs are Member and family driven, using a team approach with shared decision-making that facilitates the development of mutually agreed-upon care plans. With Member consent, active family/guardian/natural supports involvement is integral to treatment and discharge planning unless contraindicated.

Additionally, MBHP network providers deliver behavioral health services in a manner which supports:

- ☐ Clinical excellence and innovation in the provision of care;
- ☐ Ethical care and professional integrity;
- ☐ Member accessibility;
- ☐ Integration of behavioral health and physical health throughout all service delivery processes;
- ☐ Coordination of care including integration with primary care clinicians (PCCs);
- ☐ Data-driven practice, including evidence-based practices, outcomes measurement, and utilization management; and
- ☐ Technical competence and innovation.

Components of Service	
Recovery and Wellness	1. All program policies and procedures are designed to promote acceptance of Members into their contracted services within an atmosphere of trust: a. At all levels of motivation and readiness; and b. With any reasonable personal preferences. Additionally, it is considered best practice to have the capability to accept and treat Members presenting with various co-morbid conditions. 2. Programs promote Members' recovery, empowerment, and use of their strengths and their families' strengths in achieving their clinical, recovery, and wellness goals and improving their health outcomes. 3. Programs integrate peer/family support services whenever possible, within their own programming and/or through active linkages with community resources. 4. Programs complement and integrate their services with the following formal and informal resources and programs: a. Recovery-oriented and peer-operated services and supports; b. Wellness programs that promote skill-building, vocational assistance, supported employment, and full competitive employment; c. Natural community supports for Members and their families; d. Self-help including Anonymous recovery programs (e.g., 12-step programs) for Members and their families; and e. Consumer/family/advocacy organizations that provide support, education, and/or advocacy services, such as Parent/Professional Advocacy League (PPAL), the Federation of Children with Special Needs, Recovery Learning Communities (RLCs), Clubhouses, the National Alliance on Mental Illness (NAMI), etc. 5. Programs provide ongoing, documented in-service training that includes principles of wellness, recovery, and resilience pertaining directly to the population served. 6. Programs incorporate recovery principles and practices in their ongoing service delivery as well as in quality improvement activities.

Cultural Competence	1. The program provides services that accommodate the Member consider the Member's family and community contexts and build on the Member's strengths to meet his or her behavioral health, social, and physical needs. 2. The program staff has the skills to recognize and respect the behaviors, ideas, thoughts, communications, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care and to further support cultural and linguistic competence. 3. The provider makes best efforts to ensure access to qualified clinicians able to meet the cultural, linguistic, ethnic, and other unique needs of all Members served in their local community, directly or by referral, including members of minority groups, those who are homeless, Members who are disabled, Members who are deaf or hard of hearing, and other populations with special needs. a. Providers ask Members' language of choice. b. Because clinical staff with linguistic capacity is preferable to interpreters/translators, providers offer the Member a clinician who speaks his/her language of choice whenever possible, or refers him/her to a provider who can do so. c. The provider has access to qualified interpreters/translators and translation services, experienced in behavioral health care, appropriate to the needs of the population served. If the program must seek interpreter/translation services outside of the agency, it maintains a list of qualified interpreters/ translators to provide this service, as well as relevant resources. Interpreter/translator services are provided at a level which enables a Member to participate fully in the provider's clinical program. 4. Any written documentation is made available for Members in a manner, format, and language that can be easily understood by those with limited English proficiency. Such materials, especially discharge documents, are translated into languages considered prevalent. It is considered best practice to have the capability to translate such materials into the Member's preferred language when requested by the Member. 5. Programs provide ongoing in-service training that includes cultural and linguistic competency issues pertaining directly to the population served, to ensure its staff demonstrate an understanding of and respect for Members' diverse cultural, linguistic, and other unique needs.

	6. Programs include cultural and linguistic competence in their ongoing quality assessment and improvement activities, including identifying and reducing the existence of health care disparities.
Consent for Treatment	1. The provider identifies the Member's custodial status and obtains all consent forms and releases of information in compliance with that status. 2. The provider obtains a consent-to-treatment form signed by the Member or parent/guardian/caregiver. 3. The provider obtains appropriate consent for information sharing in order to coordinate care. 4. The provider is in compliance with current laws and standards regarding consent and release of information and conducts staff training as changes occur. 5. If the Member or parent/guardian/caregiver of a minor declines or restricts the consent for coordination, the provider documents this as such in the Member's health record. Attempts are continually made and documented to engage the Member in giving consent, as appropriate to his/her treatment plan.
Staffing Requirements	
	1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the MBHP service-specific performance specifications, and the credentialing criteria outlined in the MBHP Provider Manual, Volume I, as referenced at www.masspartnership.com. If there are discrepancies between MBHP performance specifications and any licensing body, the requirements of the licensing body take precedence. 3. Organizations that have staff who do not meet the credentialing criteria for a specific level of care may apply for a waiver for such staff person(s) through MBHP's waiver process as outlined in the MBHP Provider Manual. 4. The provider ensures that program staff are qualified through education, experience, and/or training to provide support and treatment to the population served by the programs. 5. The provider follows documented internal policies and procedures for training and supervising staff, the components of which include:

a. Orientation and ongoing information about the provider's policies and procedures.
b. Orientation and ongoing information about MBHP policies and procedures including but not limited to:
   i. Provider Manual;
   ii. Medical Necessity criteria;
   iii. Authorization parameters and procedures;
   iv. Performance Specifications for the level(s) of care provided;
   v. Per Diem/Per Services Definitions;
   vi. Adverse Incident Reporting; and
   vii. Alerts
c. At least annual staff training that promotes skill development in clinical and rehabilitation services appropriate to the level of care and the population served, including but not limited to training on recovery and wellness, the consumer/family perspective, and integration and care coordination with PCCs. Provided;
d. Staff participation in supervision and consultation appropriate to their degree and licensure level, and in compliance with MBHP's credentialing criteria and service-specific performance specifications. The provider maintains documentation of staff supervision and consultation policies and procedures as well as provider compliance with those policies and procedures, and, upon request, provides this documentation to MBHP.

6. For all clinical reviews with MBHP, the provider must utilize an appropriately MBHP-credentialed clinician for that service (see MBHP credentialing criteria at www.masspartnership.com). When requested by MBHP, the provider will make an MD available for physician to physician reviews.

Process Specifications

Access, Assessment, Treatment/ Care Planning, and Documentation	1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. The provider offers hours of operation comparable to those offered to individuals with commercial insurance or to Medicaid Fee-for-Service if only MassHealth Members are served. 3. The provider reports bed/service availability as required by MBHP on the Massachusetts Behavioral Health Access website, www.MABHAccess.com, for all levels of care included in the website 4. The provider manages services to reduce and eliminate the necessity of maintaining waiting lists. Providers who are not able to offer access that complies with the MBHP access standards as outlined in the MBHP Provider Manual, Volume I, as referenced at www.masspartnership.com, must refer Members to another MBHP provider to ensure that Members receive services in a timely manner. Providers contact MBHP for assistance with making referrals as needed. If there are barriers to accessing covered services, the provider notifies the MBHP Clinical Access Line and/or the regional office as soon as possible to obtain assistance. All such activities are documented. 5. With consent, the Member and his/her parent/guardian/caregiver, family members other natural supports are active and integral participants throughout the service delivery process, including assessment, treatment planning , treatment services, discharge planning, and related meetings. All such activity is documented in the Member's health record. 6. The provider makes best efforts to offer meetings, such as treatment planning meetings, and services, such as family therapy sessions, at times and locations convenient to the Member and the family's schedule, including evening and weekend meeting times and the use of teleconferencing.

	7. With consent, the Member's PCC, other behavioral health providers, state agency staff, and other supports are engaged in treatment and discharge planning meetings. 8. The provider completes an initial written, comprehensive assessment for all Members entering any level of care, which is documented in the Member's health record. 9. The assessment includes, but is not limited to: history of presenting problem; chief complaints and symptoms; strengths; behavioral health, medical, developmental, family, and social history; linguistic and cultural background; for youth in the care/custody of the Commonwealth, history of out of home placements; mental status examination including assessment of suicide and violence risk; previous medication trials, current medications, and any allergies; DSM-5 diagnosis and clinical formulation that are supported by the clinical data gathered, rationale for treatment, and recommendations; level of functioning; current and past substance use; and name of PCC and other key providers. 10. For adults, the initial outcome measurement is administered prior to or on the date of the comprehensive assessment completion to document that the clinical data was integrated into the initial assessment process. Information in the assessment may be gathered from the Member, family/guardian/caregiver, the referral source, past and current treaters, and/or other collateral contacts, with appropriate consent. 11. When requested and/or as indicated by the individual's clinical presentation, the provider conducts and documents in the Member's health record a substance use disorder assessment either directly or by linkage with a provider trained in substance use disorders. 12. The provider completes a comprehensive and individualized initial treatment plan built upon the assessment and developed with the Member and/or parent/guardian/caregiver, and, with consent, family members, the PCC, other involved providers, and supports identified by the Member. a. The treatment plan is signed, dated, and documented in the Member's health record. b. The treatment plan includes, but is not limited to: objective and measurable goals, time frames, expected outcomes, the Member's strengths, links to primary care especially for Members with active co-occurring medical conditions, a plan to involve a state agency case manager, when appropriate, and treatment recommendations consistent with the service plan of the relevant state agency, if involved. c. The treatment plan is consistent with the Member's diagnosis, describes all services needed during the course of treatment, and reflects continuity and coordination of care. d. The time frames for the completion of the initial treatment plan are delineated in each of the service-specific performance specifications.

	13. The provider assigns a multi-disciplinary treatment team to each Member within the time frames delineated in each of the service-specific performance specifications. A multi-disciplinary treatment team meets to review the assessment and initial treatment plan and discharge plan within time frames delineated in each of the service-specific performance specifications. 14. The treatment plan is implemented, reviewed, and revised throughout the course of treatment, based on the provider's continual reassessment of the Member and with the Member's participation. The Member's progress in achieving the treatment goals is documented in progress notes and treatment plan updates in the Member's health record. 15. If the Member terminates treatment without notice, every effort is made to contact the Member to re-engage in treatment or to provide assistance to transfer the Member to another appropriate source of care prior to discharging the Member. Such activity is documented in the Member's health record. When the Member is identified as having state agency and/or other collateral involvement, or is participating in MBHP's Integrated Care Management Program (ICMP), and appropriate releases of information have been signed by the Member/parent/guardian/caregiver, those collateral contacts, including the Member's PCC, and/or MBHP's integrated care manager are informed of the Member's treatment status.
Care Coordination	1. The provider seeks informed consent from the Member in order to coordinate admissions, assessment, treatment/care planning, and discharge planning with the following collaterals, as appropriate to the level of care. The type and amount of information shared is appropriate to the purpose and the role of those to/from whom the information is being communicated/requested, including the following: a. Parents/guardians/caregivers/family/significant other/natural supports; b. PCC; c. ESP and MCI; d. 24-hour levels of care, including psychiatric hospitals, Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT) programs, Community Crisis Stabilization (CCS), etc.; e. State agency personnel (when providing services to Members involved with a state agency), including DMH, DCF, DYS, DPH, DDS, and/or DTA;

	f. Local education authority (LEA) (applies to all children, whether a regular education or special education student); g. Police departments and local court systems; h. Outpatient treaters and prescribers; i. Other community-based providers, including CBHI services such as In-Home Therapy (IHT) and Intensive Care Coordination (ICC), Community Support Programs (CSPs), and substance use disorder programs; or j. Other collaterals appropriate to the Member and/or the level of care. 2. Care coordination efforts are documented in the Member's health record. 3. When additional or complex integrated care coordination is needed, the provider refers Members to MBHP's Integrated Care Management Program (ICMP) according to the referral criteria outlined in the MBHP Provider Manual, Volume 1, as referenced at www.masspartnership.com.
Discharge Planning and Documentation	1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. The provider ensures that staff who are responsible for discharge planning are knowledgeable about the continuum of behavioral health and medical services as well as other services and supports in the community, and discharge planning skills and strategies. 3. Staff involved in discharge planning are trained on the use of the www.MABHAccess.com website and are expected to utilize this resource to locate available step-down and other aftercare services for Members. 4. The provider identifies barriers to discharge planning and aftercare and develops strategies to assist the Member with arranging and utilizing aftercare services, making best efforts to ensure that the discharge plan (or other such document(s) that contain the required elements) is consistent with his/her benefit coverage. 5. As appropriate, the provider assists the Member in scheduling a follow-up appointment for the Member with his/her PCC. 6. With the Member's consent, the provider, in collaboration with the Member, his/her family, and/or his/her supports, develops a written, individualized, person-centered, strengths-based discharge plan (or other such document(s) that contain the required elements), prior to the Member's discharge from any inpatient service or, if appropriate,

	any other behavioral health service, that is documented in the Member's health record. Prior to the Member's discharge, the provider provides the Member with a copy of the discharge plan (or other such document(s) that contain the required elements). The plan includes, but is not limited to: a. Identification of the Member's needs, including but not limited to: i. Housing; ii. Finances; iii. Medical care; iv. Transportation; v. Family, employment, and educational concerns; vi. Natural community and social supports; and vii. For Members discharged from inpatient mental health services and for other Members as clinically indicated, an updated crisis prevention plan for adults that follows the principles of recovery and resilience, or an updated safety plan (as part of the Crisis Planning Tools http://www.masspartnership.com/index.aspx) for youth and their families, and/or a relapse prevention plan, as applicable. Such a plan is directed by the Member and is designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. It identifies triggers that may lead to or escalate a psychiatric crisis, and includes a preferred disposition as well as the Member's preferences. With Member consent, the plan may be implemented by an ESP/MCI provider, a medical or behavioral health provider, the PCC, or another individual as directed by the Member. b. A list of the services and supports that are recommended post-discharge, including identified providers, PCCs, and other community resources available to deliver each recommended service; c. A list of prescribed medication, dosages, and potential side effects; and d. Treatment recommendations consistent with the service plan of the relevant state agency for Members who are state-agency involved; and e. For all ICC-involved youth, the discharge plan is consistent with the youth's Individual Care Plan (ICP).

	7. For all youth under the age of 21, the provider makes best efforts to ensure a smooth transition for the return to home or discharge location, and to the next service, if any, by: a. Linking to necessary services and making appropriate referrals, including Children's Behavioral Health Initiative (CBHI) services and Community Support Program (CSP), if indicated; b. Documenting in the Member's health record all efforts related to these activities, including the Member's and family's/guardian's/caregiver's active participation in discharge planning; c. Reviewing and updating any of the Crisis Planning Tools (safety plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan), in collaboration with the youth, family, ICC provider if enrolled in ICC, and, if indicated, with the youth's ESP/MCI provider, and sending a copy to those providers where consent is given; and d. Educating the youth and family regarding use of the ESP/MCI service if needed in the future including access to their mobile and other community-based services. 8. Additional discharge planning requirements for Members who are homeless: a. The provider makes all reasonable efforts to discharge any homeless Members to living situations other than emergency shelters. b. The provider provides comprehensive discharge planning for all homeless Members, exhausts all potential avenues to secure placement or housing resources, and utilizes all community resources to assist with discharge planning. c. The provider completes and forwards to DMH within two business days of admission a DMH Service Authorization packet for Members who are homeless, who appear to meet DMH clinical criteria for service eligibility, and who have not already been determined eligible for DMH Continuing Care Services. d. The provider documents in the Member's health record all efforts related to these activities. 9. For Members who are minors: if reasonable attempts have been unsuccessful to involve their parents/guardians/caregivers in treatment and discharge planning, and/or the parents/guardians/caregivers are unable to participate in planning meetings, the provider presents

	treatment findings and recommendations to parents/guardians/caregivers at the time of discharge. These findings and recommendations are documented in the Member's health record.
Service, Community, and Collateral Linkages	
	1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. Programs actively engage in collaboration with Executive Office of Health and Human Services (EOHHS)-funded programs, including but not limited to: a. Department of Mental Health (DMH)-funded programs, such as Community-Based Flexible Supports; b. Department of Children and Families (DCF)-funded programs that support the safety, permanency and well-being of youth in the Care and Custody of the Commonwealth; c. Bureau of Substance Abuse Services (BSAS)-funded programs for Members, such as recovery homes to promote continuity of services for substance use disorders from acute care to supportive and rehabilitative care and recovery supports; d. Department of Developmental Services (DDS) programs that involve rehabilitative and habilitative services for persons with developmental disabilities; e. Department of Youth Services (DYS) programs that help Members stay in the community and avoid recidivism to DYS; f. Other programs and initiatives within EOHHS, MassHealth, and Department of Public Health (DPH) related to PCC coordination and pharmacy management, including federal and state grant programs; and g. Prevention and wellness programs at the state, regional, and local level. 3. The provider develops a working relationship with the ESP/MCI provider that covers the catchment area in which the program is located. The provider: a. Responds to referrals from the ESP/MCI to their programs in a timely fashion. b. Trains staff on the appropriate use of the ESP/MCI services, including services available in the community as alternatives to hospital Emergency Department visits.

	c. Ensures that staff educate Members about the availability of ESP/MCI services 24 hours per day, 7 days per week, 365 days per year, including how to access services from the local ESP/MCI in the community. d. Educates staff, Members, and their families about engaging Members in the development of crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable, and, with Member consent, sending a copy of these plans to the ESP/MCI Director at the Member's local ESP/MCI. 4. The provider makes reasonable efforts to assist Members with identifying transportation options, when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

Primary Care Clinician (PCC) Integration	
	1. Throughout the course of treatment, as applicable, and with appropriate consent, to ensure integration of care the provider assesses and makes inquiries about the Member's medical/health status, utilization of medical visits, and compliance with medical treatment through: self-report; communication with the Member's PCC and/or other healthcare professionals identified by the Member; and communication with MBHP. 2. The provider identifies the Member's PCC. If there is none, the provider makes best efforts to assist the Member in obtaining a PCC by: directing him/her to the telephone number for MassHealth's Customer Service Center located on the back of his/her MassHealth ID card; directing him/her to the PCC section of the MBHP website which contains the telephone number for MassHealth's Customer Service Center; or directly providing him/her with the telephone number for MassHealth's Customer Service Center. 3. The provider obtains a release of information to contact the PCC. If the Member declines, the provider documents this in the Member's health record and continues to engage the Member around this issue.

	4. The provider communicates with the Member's PCC via telephone or in writing with Member/guardian consent, and such communication is documented in the Member's health record. For inpatient and 24-hour diversionary services, this communication takes place within one business day. For all other services, this communication takes place within five (5) business days. 5. The provider contacts the PCC for the following purposes: a. To notify him/her regarding admission or enrollment in services and the reason(s) for such admission/enrollment; b. To obtain information regarding health status, including but not limited to medical and medication information; c. To coordinate assessment, treatment and discharge planning; d. To share diagnostic and treatment/care plan information; e. To coordinate medication, if applicable; and f. To notify him/her of discharge and involve him/her in discharge and/or aftercare planning as indicated. 6. With appropriate consent, the provider maintains ongoing communication and collaboration with the PCC for these purposes, as well as to provide information to the PCC about the course of the Member's behavioral health treatment, including psychopharmacology and notable metabolic studies and/or other medical information. The provider utilizes information from the PCC to inform the Member's assessment, treatment/care plan and discharge plan on an ongoing basis. 7. To facilitate communication between the behavioral health provider and the PCC, providers of all levels of care are encouraged to utilize the "Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form." This form can be located at www.masspartnership.com in both the "For PCCs" and "For BH Providers" sections.

Quality Management (QM)	
Compliance With Laws and Regulations	1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. Providers are required to comply with all applicable state and federal laws, regulations, licensing, policies, and accreditation requirements. The provider immediately notifies MBHP of the revocation, limitation, suspension or other conditions placed on the license, certification, or accreditation.
Quality Measurement and Improvement Initiatives	1. Providers are expected to participate in and implement results from the quality measurements and improvement initiatives conducted by MBHP. Providers integrate these quality improvement opportunities into their Quality Improvement Plans as referenced below. MBHP quality measurement and improvement initiatives include but are not limited to: a. On-site program reviews; b. Health record reviews; c. Outcomes measurement initiatives; d. Utilization management initiatives; e. Member satisfaction surveys conducted on-site, telephonically and/or via written survey by consumer satisfaction teams; f. Provider satisfaction surveys; and g. Provider profile reports. 2. The provider maintains utilization management policies and procedures to ensure that medical necessity and level of care criteria are met and documented in the assessment, treatment plan, and progress notes in each Member's health record, and that appropriate lengths of stay are managed across the program.
Measurement of Treatment Outcomes	1. Providers are expected to select and utilize a standardized outcomes measurement tool, approved by MBHP, and implement all requirements relative to this initiative as outlined in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.

Provider Quality Improvement Programs and Plans	1. Network providers are required to have internal processes, policies, procedures, programs and/or activities aimed at monitoring and improving quality of care. 2. The provider identifies a manager responsible for the provider's quality improvement process. 3. Providers work collaboratively with MBHP staff in developing, implementing and monitoring quality improvement plans in response to adverse incidents, concerns and grievances, or such quality initiatives as provider profiles, health record reviews, etc. 4. Providers engage Members, families, and other relevant stakeholders in their quality management activities.
Adverse Incident Reports	1. Providers of all levels of care are required to comply with the guidelines for reporting all Adverse Incidents, identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section. 2. All 24 hour level-of-care providers are required to report all Adverse Incidents within 24 hours of their occurrence. 3. Providers of all other levels of care – outpatient and all non-24 hour levels-of-care, with the exception of ECT – are required to report, within 24 hours of their occurrence, Member deaths, serious injuries requiring urgent or emergent treatment that occurred while a Member was at a practitioner/provider site, and serious attempted suicides that occur during the time span that a Member is receiving services from the provider, during and outside a treatment session.
Concerns and Grievances	1. Any concerns and dissatisfaction with MBHP's services, access to care, and/or the quality of care received from network providers can be reported to any MBHP staff, or directly to MBHP Quality Management Specialists. A verbal concern and/or a written grievance can be submitted to MBHP for investigation and resolution. All related requirements are identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.
Provider Concerns	1. MBHP encourages its network providers to relay any concerns they have regarding any aspect or action of MBHP or its providers. This includes, but is not limited to, quality of care, administrative operations, and access to care. All requirements and the review process are further identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.

Restraint and Seclusion	1. MBHP supports the principles that guide the use of restraints and/or seclusion put forward by the Massachusetts Coalition for the Prevention of Medical Errors. Network providers are responsible for compliance with all applicable federal and state laws and regulations governing the restraint and/or seclusion of Members (104 CMR 27.12 and 28.05, and 42 CFR 441.151 subpart D and 483 subpart G). All requirements are identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.
Member Rights	1. Network providers are responsible for compliance with Massachusetts laws, policies, and regulations governing Member rights and privileges. All requirements are identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.
Health Record Maintenance	1. Providers are required to meet all requirements related to maintenance of health records, including documentation of the following in the Member's health record: demographic information; clinical history; behavioral health clinical assessments; treatment plans; services provided; contacts with the Member, his/her family, guardians, or significant others; and treatment outcomes. 2. Health records are made available to MBHP when requested. Requests to review health records on-site can occur within 24 hours of notice. Health records requested by MBHP must be received at MBHP offices within 10 business days of request.
Satisfaction Surveys	1. Providers are expected to work with MBHP to improve services based on data derived from Member and provider satisfaction surveys conducted by MBHP. 2. Providers are encouraged to conduct satisfaction survey(s) including the following: a. Members b. Family members c. Other stakeholders such as referral sources, other behavioral health providers, community resources, state agencies, PCCs 3. Members are encouraged to utilize data derived from satisfaction surveys to inform provider's quality improvement efforts.

EMERGENCY SERVICES PROGRAM (ESP)

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers contracted for this service and all contracted services are held accountable to the General performance specifications**, located at the beginning of the performance specifications section of the Provider Manual, found at www.masspartnership.com. Additionally, providers contracted for this service are held accountable to the Mobile Crisis Intervention performance specifications, as well as to the Community Crisis Stabilization performance specifications. The requirements outlined within these service-specific performance specifications take precedence over those within the General performance specifications.

Philosophy

The Emergency Services Program (ESP) provides crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year (24/7/365) to Members of all ages who are experiencing a behavioral health crisis. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows a Member to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with a Member in crisis, the ESP provides a core service including crisis assessment, intervention, and stabilization. In doing so, the ESP conducts a crisis behavioral health assessment and offers short-term crisis counseling that includes active listening and support. The ESP provides solution-focused and strengths-oriented crisis intervention aimed at working with the Member and his/her family and/or other natural supports to understand the current crisis, identify solutions, and access resources and services for comfort, support, assistance, and treatment. The ESP arranges the behavioral health services that the Member selects to further treat his/her behavioral health condition based on the assessment completed and the Member's demonstrated medical need. The ESP coordinates with other involved service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. The ESP also provides the Member and his/her family with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community. While it is expected that all ESP encounters minimally include the three basic components of crisis assessment, intervention, and stabilization, crisis services require flexibility in the focus and duration of the initial intervention, the Member's participation in the treatment, and the number and type of follow-up services.

ESP services are directly accessible to Members who seek behavioral health services on their own and/or who may be referred by any other individual or resource, such as family members, guardians, community-based agencies, service providers, primary care physicians, residential programs, schools, state agency personnel, law enforcement, courts, etc. ESP services are community-based in order to bring treatment to Members in crisis, allow for Member choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery. Local ESPs provide crisis behavioral health services in the community, through mobile crisis intervention services, accessible community-based locations, and Community Crisis Stabilization (CCS) programs.

The mission of the ESP is to deliver high quality, culturally competent, clinically and cost- effective, integrated community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, wellness, and recovery

Components of Service	
	1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. The ESP provider is contracted to provide crisis behavioral health services in a specified catchment area in the Commonwealth of Massachusetts. 3. The Emergency Services Program (ESP) is a comprehensive, integrated program of crisis behavioral health services, including services delivered through the ESP's mobile crisis intervention services for adults, through MCI services for youth, in the ESP's accessible, community-based location, and in the ESP's Community Crisis Stabilization (CCS) program. 4. This covered service includes the following: crisis screening, which for the purposes of these performance specifications will be referred to as "crisis assessment"; short-term crisis counseling, which for the purposes of these performance specifications will be referred to as "short-term crisis counseling" as well as "crisis intervention"; crisis stabilization, which will be referred to as "crisis stabilization" in these performance specifications; and medication evaluation and Specialing, both of which are arranged by ESP providers when needed by Members participating in ESP services. While the "core" ESP services are referred to throughout this document as "crisis assessment, intervention, and stabilization," it is understood that all recipients of ESP services have access to all the services listed above: crisis screening, short-term crisis counseling, crisis stabilization, medication evaluation, and Specialing. 5. The ESP provides a discrete level of care that minimally includes the core ESP services – behavioral health crisis assessment, intervention, and stabilization – to all recipients of ESP services in all ESP service components and venues. 6. The ESP conducts all clinical, medical, quality, administrative, and financial oversight functions across all the services provided by the ESP and all locations in which these services are provided, including any ESP services provided by subcontractors. More specifically, management functions include: • Staff recruitment, hiring, training, supervision, and evaluation • Triage • Clinical and medical oversight • Quality management/risk management • Information technology, data management, and reporting • Claims and encounter form submission • Oversight of subcontracts • Interface with payers including the MassHealth-contracted Managed Care Entities (MCEs)

	• Interface with MBHP for contract management purposes 7. The ESP provides services to all uninsured individuals as well as those enrolled in or covered by the following payers: MassHealth plans including the PCC Plan (MBHP), the MassHealth-contracted MCEs and MassHealth fee-for-service or "unmanaged" plans, DMH only, Medicare, and Medicare/Medicaid. • Payment will not be provided to ESPs for ESP or CCS services for individuals with commercial insurance. ESPs are not mandated to provide ESP and/or CCS services to those populations, and any resulting contract with MBHP shall not require ESPs to provide ESP and/or CCS services to such populations. ESPs are encouraged to seek contracts with commercial payers for the provision of ESP and CCS services to their members. 8. ESP services are available to Members of all ages. 9. ESP services are available to Members who present with mental health, substance use, and/or co-occurring mental health and substance use disorders. 10. The ESP ensures that ESP services are accessible throughout the entire catchment area 24/7/365. 11. The ESP responds to all requests for crisis assessment, intervention, and stabilization in a timely fashion, in order to be responsive to the Member's and/or caretakers' sense of urgency, intervene in behavioral health crises early, and prevent the adverse impact that treatment delay may have on Members, families, and settings in which those Members await these services, particularly hospital emergency departments (EDs), in order to minimize the duration of Members' time in this more restrictive setting, thereby contributing to efforts to reduce ED overcrowding and boarding. The ESP ensures that a maximum response time of 60 minutes from the time of the Member's readiness for ESP crisis assessment is provided in every encounter and maintained across its program. 12. All ESP services in a given catchment area are accessed by phone through a toll-free number (TFN), which may include an 800, 888, 877, or 866 number, operated by the contracted ESP provider 24/7/365. The TFN is generally expected to operate at the ESP's community-based location. The TFN, accessible by voice or Teletype (TTY), is published in all major telephone directories in the ESP's catchment area, under both "Mental Health Services" and "Substance Abuse Services." 13. The ESP triages calls to its most appropriate ESP service component, the one that will provide crisis behavioral health services to the Member in the least restrictive setting, ensuring safety and responsiveness to Member and family choice. 14. The ESP ensures that, upon the request of a court clinician conducting a psychiatric evaluation pursuant to M.G.L. c. 12312(e), a crisis assessment is provided, appropriate diversionary services are identified, and assistance is provided to access the diversionary service.

15. The ESP's priority is to ensure safety by providing immediate intervention in life-threatening situations involving imminent risk of suicide, homicide (except in cases where law enforcement is clearly needed), or significant violence directed toward self, person(s), or property.
16. The ESP supports resiliency, wellness, and recovery of all Members to whom it provides crisis behavioral health services, by integrating mental health, substance use disorder, and integrated wellness and recovery principles and practices throughout the service delivery model and implementing specific recovery-oriented services, including Peer Specialist and Family Partner services.
17. The ESP must provide assessment of current or past use of substances and indications for arranging immediate medical treatment or medical follow-up, including the capacity to screen for intoxication or withdrawal.
18. The ESP operates a community-based location that serves as a primary venue through which the ESP provides community-based access to the core ESP services of crisis assessment, intervention, and stabilization.
    a. The ESP provides ESP services on site at its community-based location for a minimum of 12 hours per day on weekdays and 8 hours per day on weekends. Recommended minimum hours are 7 a.m. to 11 p.m. on weekdays and 11 a.m. to 7 p.m. on weekends. ESPs operate adult mobile crisis intervention services, MCI services for youth and the CCS 24/7/365.
    b. It is generally expected that all ESP services are located at, and in the case of adult mobile crisis intervention services and MCI for youth, dispatched from, the ESP's community-based location.
    c. The ESP's community-based location must be an easy-to-find, centrally located, handicap accessible site in a population center within the catchment area and perceived as "in the community" to those who live there. The site must be accessible to persons relying on public transportation.
    d. The ESP's community-based location offers an environment that encourages Members and families to seek crisis services in this less restrictive, community-based setting. The physical environment and interpersonal climate is one that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support. Concurrently, the environment communicates that this is a setting to receive help for crisis behavioral health needs rather than for routine services or general support and socialization.
    e. The ESP may operate more than one community-based location and/or operate mobile services from more than one location throughout the catchment area.
19. The ESP provides mobile crisis intervention services to both adults and youth (via MCI services for youth) as an integral part of its comprehensive behavioral health crisis services continuum and as a key strategy in reducing the use of unnecessary hospital ED and

inpatient psychiatric services. (Refer to the MCI performance specifications for more details about ESP/MCI provider requirements relative to that ESP service component).

20. The core ESP service of crisis assessment, intervention, and stabilization is provided to adults primarily through the ESP's adult mobile crisis intervention services, in addition to ESP services provided to adults at the ESP's community-based location. The ESP provides adult mobile crisis intervention services to any community- based location, including private homes, from 7 a.m. to 8 p.m. Outside of those hours, adult mobile crisis intervention services are provided in residential programs and hospital EDs. Upon request, ESPs are also expected to conduct crisis behavioral health assessments on medical floors in hospitals within the ESP's catchment area. ESP performance is measured against established targets for the percentage of services that are provided on a "mobile" basis, exclusive of hospital EDs.
21. The ESP operates a Community Crisis Stabilization (CCS) program that serves adults ages 18 and older, which shall include services under the Children's Behavioral Health Initiative (CBHI) for young adults from ages 18 to 21. The ESP's CCS is co-located with the ESP community-based location. (Refer to the CCS performance specifications for more details about ESP provider requirements relative to that ESP service component).
22. The ESP provides adult and child psychiatric consultation 24/7/365 to ESP/MCI clinicians and supervisors. The ESP provides access to routine, urgent or emergent face-to-face psychiatric and medication evaluations through which medication is prescribed according to written policies and procedures and applicable Massachusetts General Laws and Regulations.
23. The ESP continually assesses risk for Members who participate in ESP services, as well as for staff who provide them, and takes action to mitigate risk to the extent possible. Strategies include but are not limited to:
    a. Offering various venues for services, obtaining supervisory consultation around these triage decisions, and utilizing the hospital ED for those Members who require the services of that setting
    b. Technology resources, including cell phones with GPS and laptops
    c. Staffing infrastructure, including Certified Peer Specialists, Family Partners, and bachelor's-level staff, who provide support and comfort to Members and families, as well as to be available to provide a two-person response, along with a master's-level clinician, to many requests for adult mobile crisis intervention services and MCI services for youth.
    d. Specific "safety" staffing in the ESP's community-based location, whose role and title is defined by the ESP in a manner that helps to promote a calm and safe environment, mitigate risk, and facilitate safety in this setting. The ESP chooses to use these positions in a variety of ways that contribute to a safe environment. In part, this staffing will enable the provider to

	ensure that at least two staff are present in the community-based location during at least high-volume operating hours. 24. Subject to applicable state and federal regulations that entitle MassHealth Members to seek emergency services for an Emergency Medical Condition, the ESP strives to interrupt patterns of over-reliance on hospital EDs as the first point of contact in the event of a behavioral health crisis. The ESP is organized around the diversion of behavioral health utilization from those settings when there is not a physical condition or level of acuity that requires medical assessment and intervention, while understanding that MassHealth Members are entitled to seek emergency services in an ED if they believe they have an Emergency Medical Condition. The ESP develops and implements specific strategies to change referral and utilization patterns in its communities and shift volume from hospital EDs to its community-based services, specifically its adult mobile crisis intervention services and MCI services for youth, ESP community-based locations, and CCSs. The ESP creates a service pathway that screens for the need to refer up to a hospital ED rather than step-down from hospital-based emergency care. 25. The ESP identifies and implements strategies that maximize utilization of community-based diversionary services and reduce unnecessary psychiatric hospitalization, in a manner that is consistent with medical necessity criteria. 26. The ESP is responsible for arranging transportation for Members, inclusive of private ambulances, to the appropriate levels of care determined for disposition. The ESP also provides transportation arrangement for Members and their families to and from the ESP, home setting, or appropriate outpatient and/or medication service following an ESP intervention. The ESP assists Members to arrange MassHealth transportation benefits. 27. The ESP practices in accordance with all Alerts issued by MBHP, including: a. Network Alert #87, July 2001 Medical Clearance Guidelines for Emergency Services Programs (ESP) & Acute Inpatient Facilities: A Consensus Statement b. Provider Alert #24, October 2007 Emergency Behavioral Health Services Policies and Procedures for Emergency Services Programs and Hospital Emergency Departments for MBHP Members and Uninsured Consumers c. Provider Alert #116, June 2012 Behavioral Health Care Access, Quality, and Discharge Protocol for DYS and MBHP d. Provider Alert #113, April 2012 Protocol for Accessing Acute Behavioral Health Care Services for Youth Involved with the Department of Children and Families (DCF) 28. The ESP implements protocols developed by MBHP regarding medical evaluation or “clearance.” The ESP refers deferentially to hospital EDs and primary care clinicians, within a timeframe that is based on the

	urgency of that need. 29. The ESP develops protocols for obtaining information related to crisis prevention plans and safety plans as part of the Crisis Planning Tools for youth, communicating the status to ESP clinicians and MBHP (if a crisis prevention plan and/or safety plan was not developed in conjunction with MBHP), and notifying relevant providers, family members, and significant others, as necessary and with the appropriate informed consent. 30. The ESP ensures that all service delivery integrates the following populations: • Children, adolescents, and their families • Adults • Persons with mental health conditions • Persons with substance use disorder conditions • Persons with co-occurring mental health and substance use disorder conditions • Persons with co-occurring behavioral health and medical conditions 31. The ESP ensures that service delivery facilitates communication, access, and an informed clinical approach with special populations including but not limited to: • Intellectual and developmental disabilities • Deaf and hard of hearing • Blind, deaf-blind, and visually impaired • Culturally and linguistically diverse populations • Elders • Veterans • Homeless • Gay, lesbian, bisexual, transgendered 32. ESPs should consistently utilize the Massachusetts Behavioral Health Access website (www.MABHAccess.com) to locate services for any and all populations, including commercial payers. 33. The ESP bills for all available third-party revenue and bills MBHP and Medicaid in accordance with the billing requirements as outlined in the ESP Amendment to Exhibit A annual contract.

Staffing Requirements

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the MBHP service-specific performance specifications, and the credentialing criteria outlined in the MBHP Provider Manual, Volume I, as referenced at www.masspartnership.com.
3. It is expected that the provider organization contracted as an ESP provider has resources to support the management and delivery of ESP services, including administrative and financial oversight, medical leadership, and technology infrastructure.
4. The ESP uses its staffing resources in an integrated and flexible manner, utilizing all available resources to respond to the needs of Members who require its services on a daily basis, with fluctuations in volume, intensity, location of services, etc.
5. ESP staffing is based on a multi-disciplinary team, including the following positions:
    a. ESP Medical Director: This is a psychiatrist who meets MBHP's credentialing criteria is responsible for clinical and medical oversight and quality of care across all ESP service components. It is expected that the ESP provider agency will appoint one of the psychiatrists, who is in the staffing pattern for the ESP and/or CCS and works directly in one or both of those service components on at least a part- time basis, as the ESP Medical Director. This individual coordinates the functions of his/her ESP medical director role, the psychiatric care delivered by him/herself and/or other psychiatric clinicians during business hours, and the after-hours psychiatric consultation function fulfilled by him/herself and/or other psychiatric clinicians. Included is the responsibility for supervising all psychiatric clinicians performing psychiatric functions in any of the ESP service components. The ESP Medical Director is responsible for developing and maintaining relationships with medical providers and other stakeholders in the catchment area, including medical directors at local outpatient, diversionary, and inpatient services programs, hospital emergency department (ED) physicians, and primary care clinicians. This individual is available for clinical consultation to ESP staff members and community partners, including negotiating issues related to medical clearance and inpatient admissions.

	b. ESP Director: The ESP Director is a full-time position. This master's- or doctoral-level, licensed behavioral health clinician shares responsibility with the ESP Medical Director for the clinical oversight and quality of care across all ESP service components. He/she is also responsible for the administrative and financial oversight of the ESP contract, along with administrative and financial leadership of the contracted ESP provider agency. The ESP Director is the primary point of accountability to MBHP for the ESP contract and is responsible for all subcontracts and interface with public payers. The ESP Director ensures compliance with all requirements set forth by MBHP, including standard clinical assessment tools, electronic encounter forms, and other data collection mechanisms. The ESP Director is responsible for ensuring the provision of the core ESP services of crisis assessment, intervention, and stabilization to Members of all ages in all ESP service components and locations, including both mobile crisis intervention services and those provided on-site in the ESP's community-based location. He/she is responsible for staff recruitment, orientation, training, and supervision. He/she provides administrative and clinical supervision to key program-level supervisory staff. The ESP Director also develops and maintains working relationships with all appropriate community stakeholders. c. Quality Management/Risk Management Director: This master's- or doctoral-level staff person has a behavioral health background and is responsible for developing and implementing the quality and risk management program across all ESP service components. The Quality Management/Risk Management Director is responsible for all MBHP reporting requirements and for utilizing data reporting to track and trend quality indicators, ensure compliance with standards of care, and implement quality improvement initiatives. This individual is responsible for managing, resolving, and reporting all adverse incidents, complaints, and grievances. The Quality Management/Risk Management Director advises clinical staff on risk assessment, crisis prevention/safety planning, and risk management. This individual is responsible for implementing and utilizing all assessment and/or outcomes tools as required by the ESP contract with MBHP and implementing stakeholder satisfaction surveys. d. Clinical Supervisors: These licensed, master's- or doctoral-level behavioral health clinicians provide clinical supervision to all direct service staff across the ESP service components. Clinical supervisors of clinicians providing ESP services to children and adolescents must be child-trained clinicians. e. Triage clinicians: These master's- or doctoral-level behavioral health clinicians answer all incoming phone calls and are responsible for triaging calls to the appropriate ESP service component, or to another appropriate resource, including 911 in

	acute emergencies. Bachelor's-level staff may answer triage calls with master's-level clinicians and supervisors available to consult with and take calls when indicated. Triage clinicians provide general information to callers, serving as a resource by assisting them in accessing care throughout the behavioral health system. Triage clinicians facilitate access to diversionary services, including setting up urgent psychopharmacology appointments, etc. f. Clinicians: These master's- or doctoral-level behavioral health clinicians provide crisis assessment, intervention, and stabilization services across all service components. Clinicians providing ESP services to children and adolescents must be child-trained clinicians. g. Psychiatry: These MDs and psychiatric nurse mental health clinical specialists (PNMHCS) who meet MBHP's credentialing criteria provide consultation across all ESP service components. h. Psychiatric consultation (after hours): These psychiatrists and/or PNMHCSs who meet MBHP's credentialing criteria provide access to child and adult psychiatry consultation outside regular business hours. This consultation is provided to ESP staff members and others involved in the assessment, treatment, and/or disposition planning for Members. Certified Peer Specialists (CPSs) help to make community-based ESP services welcoming, comfortable, supportive, and responsive to Members who utilize them and their families. i. Certified Peer Specialists provide support to the Member, update them on the ESP process as it unfolds, and offer such concrete assistance as food and drink. CPS staff convey hope and provide psycho-education, including information about recovery, wellness, and crisis self- management. They have in-depth knowledge of the particular catchment area served by the ESP and facilitate access to specific community-based resources, including recovery-oriented and consumer-operated programs. Certified Peer Specialists assist in arranging the services to which the Member is being referred after the ESP intervention, and they work with the Member and family to support them during the transition to those follow-up services. CPS staff also provide similar services in the ESP's adult mobile crisis intervention service and CCS, as staffing and time permit. The ESP is required to employ one or more Certified Peer Specialists to work in the ESP's community-based locations. j. Bachelor's-level staff supports the master's-level clinicians in providing ESP services to Members, particularly during adult mobile crisis intervention services, as well as in the community-based location. These staff members help to support the Member and his/her family, and they perform such tasks as assisting with implementing the disposition determined by the master's-level clinician. This additional support brings efficiency to the system

	by allowing adult mobile response master's-level clinicians to focus exclusively on the provision of direct clinical services. ESP providers are encouraged to hire bachelor's-level staff who are also credentialed as Certified Peer Specialists. k. Included in the staffing model for MCI services for youth are paraprofessional staff, many of whom shall also be Family Partners. ESPs are required to hire at least one Family Partner in their MCI program, preferably upon initiation of the ESP contract, or within the first six months thereof. Family Partners have lived experience as a primary caretaker of a child with Serious Emotional Disturbance. These staff shall provide support to youth during their involvement in MCI services. (Refer to the MCI performance specifications for more details about ESP provider requirements relative to that ESP service component.) l. "Safety" staff positions in the ESP community-based location serve as a flexible resource to support ESPs in maintaining a calm and safe environment, mitigating risk, and allowing services to be delivered safely in a community-based setting. ESPs may choose to use these positions in a variety of ways that contribute to a safe environment. In part, this staffing will enable providers to ensure that a minimum of two people are present in the ESP's community- based location during at least high-volume operating hours, or during low-volume hours when fewer clinical staff are working. 6. The ESP cooperates with hospitals that require ESP clinicians to be credentialed in order to provide crisis assessments in the hospital ED, according to Network Alert #19 General Hospitals Credentialing ESPs. 7. The ESP provides consultation by a psychiatrist or PNMHCS, 24/7/365. The psychiatric clinician is available for phone consultation to the ESP clinician or supervisor within 15 minutes of request. The ESP provides access to child psychiatry as detailed in the MCI performance specifications. 8. The ESP ensures access to routine, urgent or emergent face-to-face psychiatric and medication evaluations for Members assessed during an ESP intervention who require such access to these services. The ESP may utilize psychiatric staffing in its ESP and/or in its or other providers' outpatient mental health clinics to access these services. 9. The ESP ensures that all ESP clinicians and other ESP staff receive training and meet core clinical competencies in serving the following populations who represent the majority of Members who utilize ESP services. The ESP ensures 24/7/365 access to clinical staff with expertise that is consistent with the populations served: • Children, adolescents, and their families • Adults • Persons with mental health conditions • Persons with a substance use disorder conditions • Persons with co-occurring mental health and substance use disorder conditions

	• Persons with co-occurring behavioral health and medical conditions 10. The ESP ensures that all ESP clinicians and other ESP staff receive training and meet core clinical competencies in serving the following special populations. The ESP ensures 24/7/365 access to clinical staff with expertise that is consistent with the populations served: • Intellectual and developmental disabilities • Deaf and hard of hearing • Blind, deaf-blind, and visually impaired • Culturally and linguistically diverse populations • Elders • Veterans • Homeless • Gay, lesbian, bisexual, transgendered 11. All ESP staff receive ongoing supervision appropriate to their discipline and level of training and licensure, and in compliance with MBHP's credentialing criteria. For Certified Peer Specialists and Family Partners, this supervision includes peer supervision. The ESP shall ensure that any licensed subcontractor shall provide direct supervision of its clinical staff consistent with the requirements of its license.

Process Specifications

Triage, Crisis Assessment, Treatment Planning, Crisis Intervention, Stabilization, and Documentation	1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. Within the populations defined in items #7-9 in the section Components of Service earlier in this document, the ESP accepts requests/referrals for ESP services directly from Members who seek them on their own and/or who may be referred by any other individual or resource, such as family members, guardians, community-based agencies, service providers, primary care clinicians, residential programs, schools, state agency personnel, law enforcement, courts, etc. 3. The ESP triages calls to its most appropriate ESP service component that will provide crisis behavioral health services to Members in the least restrictive setting, which ensures safety and is responsive to Member and family choice. The ESP has written triage protocols, including procedures for obtaining supervisory review of triage decisions in potentially high-risk situations. 4. Triage calls may be answered by master's-level staff, or by bachelor's-level staff with master's-level clinicians and supervisors available to consult with bachelor's-level staff and take calls when indicated. The ESP is expected to develop and maintain written protocols for this back-up and decision-making regarding access to master's-level clinicians. 5. An ESP clinician begins a crisis assessment as soon as possible and no later than one hour from time of readiness. a. *Readiness* is the point at which the Member is able to participate in a behavioral health assessment. If the assessment occurs in a hospital ED, Members are considered to be ready for the behavioral health evaluation to begin when *medical clearance* has been completed, as required by each hospital ED's protocol. If the evaluation occurs in the community, *medical clearance* may or may not be required, depending on the presentation of the Member. b. *Readiness* also assumes that the Member is awake and sufficiently cleared from the effects of substances so that he or she may participate in the evaluation. c. The determination of whether a client may be psychiatrically evaluated ("time of readiness") or transferred to another level of care following an evaluation should not be based exclusively on the results of a urine or serum drug or alcohol test. 6. For all calls requesting mobile crisis intervention services: a. The ESP accepts calls from referral sources, such as residential programs and hospital EDs, that initially provide the ESP with early notification that a Member will be referred, then follow up with a second call to the ESP as soon as the Member is ready for an assessment. The ESP uses this early notification for triage,

dispatching, and staff management purposes.

b. The ESP triage clinician or other staff keeps the referral source informed about the anticipated response time, including if the ESP is unable, in rare circumstances, to respond within the required one-hour timeframe. The ESP arranges the necessary staff resources or otherwise ensures a response as close to this timeframe as possible, keeping the referral source informed in the process.

c. If an occurrence of the ESP being unable to arrive within one hour of time of readiness occurs in a hospital ED setting with MBHP Members, the ED has the option to perform the crisis assessment and intervention utilizing their own staff and then present the clinical information directly to the MBHP Clinical Access Line for review and authorization of care. If the ED chooses to do so:

   i. The ESP informs the MBHP Clinical Access Line that the ED will be doing so. If the ED has not received confirmation from the ESP that the Clinical Access Line has approved of its doing so, the ED may call the Clinical Access Line directly.

   ii. The ED must use a master's- or doctoral-level behavioral health clinician to perform the assessment.

   iii. When an ED does the assessment under these circumstances, it is expected that it will also complete the bed search, if needed, and follow the case through to disposition.

7. Triage and disposition decisions are made in conformance with the medical necessity criteria of MBHP or the individual's other payer, for authorization into each level of care within the payer's continuum of care. For MBHP Members, the ESP contacts MBHP, presents all relevant assessment information, and obtains authorization for subsequent services based on MBHP medical necessity criteria.
8. Upon presentation to the ESP, the ESP asks the Member, significant others accompanying him/her, and/or community providers about the existence of an established crisis prevention plan and/or safety plan, and/or accesses any crisis prevention plan and/or safety plan on file at the ESP for the given Member.
9. During the ESP intervention, the clinician updates any existing crisis prevention plan and/or safety plan or creates one with the Member. The plan includes the presenting problem, the specific problem to be addressed along with a treatment plan, preferred disposition plan, and the involvement of others who may be available to support the Member before or during crises (i.e., providers, agencies, significant others, and/or family members). The purpose of this plan is to expedite a Member-focused disposition based on the experience gained from past treatment interventions.
10. The ESP ensures that each crisis assessment, intervention, and stabilization episode is documented in writing. To do so, the ESP is

	required to utilize the adult and MCI standardized documentation forms. The documentation of each ESP encounter includes but is not limited to: name of Member; date and time of request; start time; location; presenting problem; mental status exam; involvement of other person(s) and agencies; action taken; clinical/diagnostic formulation; reason for rule-out of less restrictive alternatives; time of disposition; target problems to be addressed at the next level of care; and identifying information, signature, and title of staff person. The assessment includes short-term treatment planning with goals focused on pre-crisis and crisis intervention, stabilization, and disposition(s) in accordance with written crisis prevention plans and/or safety plans when available. 11. ESP assessments and dispositions are reviewed on a scheduled basis for clinical appropriateness by the ESP director, medical director, and/or designee and documented in the Member's health record within 48 hours of the intervention. Where there is a subcontract, the ESP ensures there is a similar process in place for the ESP or the subcontractor to review the subcontracted vendor's assessments and dispositions. The ESP implements an ongoing feedback loop to continually educate staff about opportunities to improve quality of care, including the identification of diversion opportunities. 12. Under the supervision of the ESP's medical director, the ESP follows written procedures for assessing medical needs (with specific sensitivity to recognizing valid medical concerns of those presenting with mental health and/or substance use disorder conditions), including the need for a medical evaluation, medical stabilization, or a referral to a hospital for emergency medical services. 13. The ESP manages the flow of communication throughout the ESP process with a given Member. ESP staff checks in with and updates Members and the family/significant others accompanying them regarding the status of the evaluation and/or disposition process no less than every 30 minutes. The ESP will similarly keep informed the referral source and/or stakeholders in the setting in which the ESP services are being provided, such as a school, residential program, or a hospital ED. 14. During and subsequent to the crisis assessment, the ESP clinician provides crisis counseling and crisis intervention. The ESP clinician listens and offers support. The ESP clinician provides solution-focused and strengths-oriented crisis intervention aimed at working with the Member and his/her family and/or other natural supports to understand the current crisis, identify solutions, and access resources and services for comfort, support, assistance, and treatment. 15. Telephonic contact is recognized as therapeutic and may be utilized when clinically indicated and as defined by internal program policies and procedures (e.g., telephone "check-in" of a Member in a residential placement as part of his or her crisis prevention plan and/or safety plan or non-life-threatening crisis calls responsive to telephonic support and problem solving). 16. While it is expected that all ESP encounters minimally include the three

	basic components of crisis assessment, intervention, and stabilization, crisis intervention requires flexibility in the focus and duration of the initial intervention, the Member's participation in the treatment, and the number and type of follow-up services. 17. The ESP is responsible for the completion and electronic submission of an encounter form for every ESP/MCI intervention provided. For each subsequent day in an intervention, the ESP is responsible for the completion and electronic submission of an abbreviated subsequent ESP/MCI follow-up encounter. These subsequent encounters are connected to the full encounter by a unique encounter ID. The ESP ensures that encounter forms are electronically submitted to MBHP within the timeframe established by MBHP.

Disposition Planning and Documentation	1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. The ESP develops and maintains protocols for assisting the ESP clinician and consulting with others in the event that there is a question and/or disagreement regarding the level of care that is medically necessary for a given Member. Protocols include the clinician's review of the disposition plan with the ESP Director and/or Medical Director and/or ESP psychiatric clinician. These ESP staff members are available to consult and collaborate with others, such as ED physicians, MBHP clinicians, and MBHP psychiatrists, to resolve the medical necessity determination and disposition as needed. 3. The ESP arranges the medically necessary behavioral health services that the Member requires to further treat his/her behavioral health condition based on the crisis assessment completed and the Member's medical needs and preferences. 4. The ESP coordinates with other involved service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. 5. The ESP provides the Member and his/her family with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community. 6. For Members assessed to meet medical necessity criteria for inpatient mental health service or another 24-hour level of care, the ESP conducts a bed search to arrange admission. 7. The ESP promotes continuity of care for Members who are readmitted to inpatient mental health services by offering them readmission to the same provider when there is a bed available in that facility. 8. For Members who meet medical necessity criteria for inpatient mental health services, or another 24-hour level of care, the ESP arranges an admission to the closest facility with a bed available, consistent with the provider network and policies and procedures of the Member's health insurance payer. The following guidelines are utilized: • Closest proximity – Referrals within the ESP's DMH Area • Moderate proximity – Referrals within a contiguous DMH Area • Extended area – Referrals in a non-contiguous DMH Area 9. For uninsured adults who meet medical necessity criteria for inpatient mental health services, the ESP must first refer to acute care (general) hospitals in closest, moderate, and extended areas, as defined above. If no general hospital has an available bed, the ESP should refer to a private psychiatric hospital. 10. MBHP recognizes that there are times that inpatient disposition has been delayed during periods of high volume. If an ESP has contacted all MBHP in-network facilities and has been unable to secure a bed, the ESP is expected to call the MBHP Clinical Access Line or MBHP regional office. During business hours, MBHP regional staff will then assist the ESP in accessing an inpatient admission through direct contact with MBHP network providers. After hours, the MBHP Clinical Access Line will support the ESP with

	information on potential bed availability. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals. 11. In the event that there are still no in-network beds available and no discharges are expected from in-network facilities within a reasonable time period of no more than six hours of the beginning of the bed search, the ESP may call out-of-network facilities. If needed, the ESP may ask the MBHP Clinical Access Line for suggestions of out-of- network facilities and related contact information. If a bed is located in an out-of-network facility, the ESP may then request an out-of-network authorization from the MBHP Clinical Access Line. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals. 12. For youth receiving ESP services in a hospital ED and assessed to meet medical necessity criteria for inpatient services or another 24-hour level of care, and there is a delay in accessing a bed, it may be necessary to board youth under age 19 for a short period of time on pediatric units or in EDs. It is the ESP's responsibility to negotiate the need for boarding with the hospital and to request a boarding authorization from the MBHP Clinical Access Line for the boarding of MBHP child/adolescent Members. If all appropriate in-network and out-of- network inpatient facilities have been contacted and a bed has not been secured for the Member, a boarding authorization will be considered by the MBHP Clinical Access Line beginning at 5 p.m., as it is less likely that new beds will become available after this time. MBHP may also authorize Specialing during boarding of children/adolescents to ensure Member safety. The ESP is encouraged to follow appropriate protocols and/or call other payers for assistance in similar situations with their covered individuals. 13. When a youth is boarded, the ESP remains responsible for continuing the bed search on an ongoing basis until disposition. Additionally, the ESP is required to re-evaluate the Member if 24 hours have elapsed since the original ESP evaluation and determination of level of care. During this process, the ESP keeps the Member, his or her accompanying parent or guardian, and the hospital ED informed on a regular basis about the status of this process. 14. For continued authorization of boarding of youth who are MBHP Members, it is the ESP's responsibility to call the MBHP Clinical Access Line daily. The ESP provides the MBHP reference number to the boarding hospital to ensure payment of the claims later submitted by the hospital. Youth who meet the medical necessity criteria for inpatient services or another 24-hour level of care should not be sent home due to the lack of an available inpatient psychiatric bed. 15. When the ESP secures a bed for a given MBHP Member, the ESP obtains an authorization (or reference number for uninsured individuals) from the MBHP Clinical Access Line and arranges transfer of the Member to the admitting facility. For individuals with other health insurance coverage, the ESP follows the appropriate authorization policies and procedures.

	16. If an ESP psychiatrist, or an ED in which they are providing services, has concerns that an inpatient provider or provider of another 24-hour level of care is requesting additional medical tests beyond what is usual and customary in order to admit a Member, the ESP psychiatrist and/or ED physician with reservations should discuss the matter with the inpatient psychiatric unit physician requesting the tests. Hopefully, both parties will come to an agreement. If not, for MBHP Members and uninsured individuals, the ESP or ED may call MBHP's Clinical Access Line to notify them of this situation and be prepared to provide the following information: date, calling facility, name of caller, facility requesting additional testing, region of requesting facility, name of Member, and what tests were requested. MBHP will address this issue with the inpatient facility on the next business day. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals. 17. The ESP follows written protocols for follow-up with the Members who received ESP services, particularly those who successfully remain in the community after ESP services, to ensure stabilization and facilitate the disposition.
Service, Community, and Collateral Linkages	
	1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. The ESP has a clear command of the local community crisis continuum - the strengths and limitations, resources, barriers, and practice patterns – and, in collaboration with MBHP, initiates strategies aimed at strengthening service pathways and the safety net of resources. 3. ESP staff is knowledgeable of available community mental health and substance use disorder services within their ESP catchment area and statewide as needed, including the MBHP levels of care and their admission criteria, as well as relevant laws and regulations. They also have knowledge of other medical, legal, emergency, and community services available to the Member and their families, including recovery-oriented and consumer-operated resources and resources for the populations listed in the Staffing Requirements section, items #9 and 10 above. 4. The ESP develops and maintains close working relationships with recovery-oriented and consumer-operated resources in its local community, including but not limited to Recovery Learning Communities (RLCs), Clubhouses, and AA/NA. The ESP develops specific linkages with the RLCs relative to warmline services, if offered by their local RLC. These working relationships are expected to be with recovery-oriented and consumer-operated organizations that support not only adults but youth and families as well.

	5. The ESP develops and maintains linkages relevant to services for children, adolescents, and families, as required in the MCI performance specifications. This knowledge includes ESP staff being fully aware of, and knowing how to access, CBHI services. 6. The ESP is knowledgeable about community-based outpatient and diversionary services, inpatient psychiatric services, and substance use disorder treatment services, including Acute Treatment Services (ATS) and Enhanced Acute Treatment Services (E-ATS), and develops working relationships with the providers of those services, ensuring effective consultation and referral processes and seamless transfer and coordination of care. 7. The ESP also communicates, consults, collaborates, refers to, and ensures continuity of care with many other resources involved with utilizers of ESP services including, but not limited to, the following: a. Primary care services and hospitals b. State agencies c. Schools d. Residential programs e. Law enforcement entities 8. With Member consent, the ESP collaborates with the Member's PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications. 9. The ESP disseminates information to Members who receive ESP services about community resources that will aid in the amelioration of stressors, including those that offer food, clothing, shelter, utility assistance, homelessness support, supported housing, supported employment, landlord mediation, legal aid, educational resources, parenting resources and supports, etc. 10. The ESP develops and maintains relationships with the hospitals in its catchment areas characterized by ongoing and consistent communication, problem solving, and planning. The ESP works with the ED to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services, as well as how to best care for Members who present for services in both the ED and ESP settings. The ESP negotiates roles with the ED, develops contingency plans for fluctuations in utilization, and creatively uses hospital and community resources to meet the needs of its communities. The ESPs/MCIs are required to collaborate with the ED to ensure that proper documentation of any intervention within the ED is appropriately shared with that facility. 11. When necessary, the program arranges transportation for crisis evaluation and disposition into each level of care within MBHP's continuum of care.

	12. When consent is given, consultations with current providers are to be made as early as possible in the assessment and disposition formulation phase and are documented within the Member's health record, including notification to an outpatient provider of where a Member was hospitalized, with appropriate consent. 13. The ESP develops and maintains a comprehensive community resource directory that is updated on an ongoing basis and is readily available to clinical staff, Members, and families. Reasonable provisions should be made to allow Members to make copies of the directory. The directory should include, but not be limited to: a. the name of the resource; b. the location/address; c. the phone number; d. the services available; e. the hours of operation, including evenings and weekends; and f. accepted payment methods.
Quality Management (QM)	
	1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. The ESP develops and maintains a quality improvement plan, at least annually, that contains improvement goals in accordance with MBHP's overall statewide improvement goals for ESPs. 3. The ESP implements all quality management tools and initiatives required by MBHP, including standardized assessment instruments, outcomes measures, stakeholder satisfaction services, health record reviews, reporting requirements, review of ESP Continuity of Care reports (profiling data), etc.

Mobile Crisis Intervention

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers of this service and all contracted services will be held accountable to the "General" performance specifications.**

Mobile Crisis Intervention is the youth (under the age of 21) -serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention will provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week.

The service includes: A crisis assessment; engagement in a crisis planning process which may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

Components of Service

	1. Mobile Crisis Intervention is youth-serving component of an emergency service program (ESP) provider. 2. Providers of Mobile Crisis Intervention services are outpatient hospitals, community health centers, mental health centers and other clinics. 3. Mobile Crisis Intervention is delivered by a provider with demonstrated infrastructure to support and ensure a. Quality Management / Assurance b. Utilization Management c. Electronic Data Collection / IT

	d. Clinical and Psychiatric Expertise e. Cultural and Linguistic Competence 4. Mobile Crisis Intervention provides mobile, community-based crisis intervention services, which are intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs) and ESP offices, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner. 5. Mobile Crisis Intervention provides crisis assessment and crisis stabilization intervention services 24 hours a day, 7 days a week, and 365 days a year. Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to 7 days. 6. Mobile Crisis Intervention includes, but is not limited to: • Conducting a mental status exam; • Assessing crisis precipitants, including psychiatric, educational, social, familial, legal/court related, and environmental factors that may have contributed to the current crisis (e.g., new school, home, or caregiver; exposure to domestic or community violence; death of friend or relative; or recent change in medication); • Assessing the youth's behavior and the responses of parent/guardian/caregiver(s) and others to the youth's behavior; • Assessing parent/guardian/caregiver strengths and resources to identify how such strengths and resources impact their ability to care for the youth's behavioral health needs; • Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care; • Assessing medication compliance and/or past medication trials; • Assessing safety/risk issues for the youth and parent/guardian/caregiver(s). • Taking a medical history/screening for medical issues; • Assessing current functioning at home, school, and in the community; • Identifying current providers, including state agency involvement; and • Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the youth and parent/guardian/caregiver(s).

	• Solution focused crisis counseling; • Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support; • Clinical interventions that address behavior and safety concerns, delivered onsite or telephonically for up to 7 days; • Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face or by phone from an on-call child psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist. 7. Mobile Crisis Intervention assesses the safety needs of the youth and family. Mobile Crisis Intervention, with the consent of and in collaboration with the youth and family, guides the family through the crisis planning process that is in line with the family's present stage of readiness for change. This includes a review and use of the set of Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) where appropriate and in accordance with the Companion Guide for Providers. As the family chooses, Mobile Crisis Intervention engages existing service providers and/or other natural supports, as identified by the youth and family, to share in the development/update of the Crisis Planning Tools (e.g., ICC, In-Home Therapy Services, outpatient therapist). The tools are reflective of action the family believes may be beneficial. This may include, but is not limited to, the following: • Contacts and resources of individuals identified by the family who will be most helpful to them in a crisis; • Goal(s) of the Safety Plan or other Crisis Planning tools as identified by the family; • Action steps identified by the family • An open-format (the Safety Plan) that the family can choose to use as needed. If a youth already has an existing set of Crisis Planning Tools, Mobile Crisis Intervention shall utilize the tools as they apply to the current situation and/or reassess the tool's effectiveness. Where necessary Mobile Crisis Intervention collaborates with the youth's parent/guardian/caregiver(s) and other provider(s), to build consensus for revisions to the tools and to share them as directed by the family.

	8. Mobile Crisis Intervention identifies all necessary referrals and linkages to medically necessary behavioral health services and supports and facilitates referrals and access to those services. Mobile Crisis Intervention also works with the youth's health plan to arrange for dispositions to all levels of care, including inpatient and 24-hour services, diversionary services, outpatient services, and ICC. 9. Mobile Crisis Intervention provides the following additional services: • Crisis counseling and consultation to the family; • Emergency medication management and consultation; • Telephonic support to the youth and family; and • Coordination with other crisis stabilization providers. 10. For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention coordinates with the youth's care coordinator, throughout the delivery of the service. For youth not in ICC, Mobile Crisis Intervention will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers who provide services to the youth throughout the delivery of the service. 11. The Mobile Crisis Intervention provider has policies and procedures relating to all components of this service. The Mobile Crisis Intervention provider ensures all new and existing staff members are trained on these policies and procedures.

Staffing Requirements	
	1. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff and maintains staffing levels as warranted by data trends. 2. Mobile Crisis Intervention is staffed with master's level clinicians trained in working with youth and families, with experience and/or training in nonviolent crisis intervention, crisis theory/crisis intervention, solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, and de-escalation techniques. 3. Mobile Crisis Intervention is also staffed with bachelor's level or paraprofessional staff experienced or trained in providing ongoing in-home crisis stabilization services and in navigating the behavioral health crisis response system that support brief interventions that address behavior and safety. 4. A board-certified or board-eligible child psychiatrist or child trained Psychiatric Nurse Mental Health Clinical Specialist is available for phone consultation to Mobile Crisis Intervention 24-hours a day and must respond within 15 minutes of a request from Mobile Crisis Intervention staff and is available for face-to-fact appointments with the youth for urgent medication management evaluations or urgent medication management appointments within 48 hours of a request if the youth has no existing provider 5. All Mobile Crisis Intervention staff receives crisis specific training through the agency that employs them. Prior to serving families independently, Mobile Crisis Intervention staff also complete 12 hours of on-the-job training in CPI or equivalent program. A master's level clinician with at least two years of crisis intervention experience supervises this training. This training is documented. 6. All Mobile Crisis Intervention staff are trained in the following: performance specifications, clinical criteria, and per diem definitions for all MCE behavioral health covered services; Systems of Care philosophy and the Wraparound process; medications and side effects; First Aid/CPR; youth-serving agencies and processes (e.g., DCF, IEP, DYS, etc.); family systems; conflict resolution; risk management; partnering with parents/guardians/caregivers; youth development; cultural competency; and related core clinical issues/topics. This training is documented. 7. Mobile Crisis Intervention staff members are knowledgeable about available community mental health and substance use disorder services within their geographical service area, the levels of care, and relevant laws and regulations. They also have knowledge about other medical, legal, emergency, and community services available

	to the youth. 8. Mobile Crisis Intervention supervises all staff, commensurate with licensure level and consistent with credentialing criteria.
Service, Community, and Collateral Linkages	
	1. As the youth-serving component of ESP providers, Mobile Crisis Intervention is integrated into the ESP's infrastructure, services, policies and procedures, staff supervision and training, and community linkages. 2. Mobile Crisis Intervention upon completion of a crisis assessment, works with the parent/guardian/caregiver(s) to provide needed crisis stabilization services and, if necessary, with the youth's insurance carrier to obtain authorization for medically necessary level of care for the youth. 3. Mobile Crisis Intervention will ensure smooth access to MassHealth behavioral health services in the area by maintaining regular communication and interagency relationships (e.g. MOU). 4. Mobile Crisis Intervention coordinates all behavioral health crisis response with the youth's existing providers, including Intensive Care Coordination (ICC), In-Home Therapy Services and outpatient providers (e.g., mentors, therapists), other care management programs and primary care provider (PCP)/primary care clinician (PCC). Mobile Crisis Intervention facilitates referrals for, and provides information on, both Medicaid and non-Medicaid services (e.g., ICC, PAL, DCF, voluntary services, in-home therapy). 5. Mobile Crisis Intervention, with required consent, makes referral to ICC, In-Home Therapy Services or other services as needed. 6. Mobile Crisis Intervention supports linkages with the family's natural support system, including friends, family, faith community, cultural communities, and self-help groups (e.g., Parental Stress Line, AA, PAL, etc.). 7. For youth with ICC/In-Home Therapy Services that provide 24-hour response, Mobile Crisis Intervention staff contacts the provider for care coordination and disposition planning. The ICC/In-home Therapy Services staff and Mobile Crisis Intervention staff communicate and collaborate on a youth's treatment throughout the mobile crisis intervention or crisis stabilization to develop a disposition plan that is consistent with the youth's Individual Care Plan (ICP)/treatment plan. With required consent, the ICC care coordinator/In-Home Therapy Services clinician is required to participate in all meetings that occur during the youth's tenure with Mobile Crisis Intervention.

	8. For youth engaged in services that do not provide 24-hour response, Mobile Crisis Intervention staff contacts the provider for the purpose of care coordination and disposition planning. Mobile Crisis Intervention staff communicates with the provider and collaborate on a youth's treatment to develop a disposition plan that is consistent with the youth's treatment plan. 9. Mobile Crisis Intervention establishes formal relationships (e.g., MOU) including collaborative education and training with local police, emergency medical technicians (EMTs), schools, child welfare, local healthcare professionals and juvenile justice to promote effective and safe practices related to the management of emergency services for youth with mental health issues and their parent/guardian/caregivers(s). 10. With obtained consent, crisis assessments occur in the youth's home setting or appropriate alternative community setting. Crisis assessments only occur in a hospital emergency department (ED) if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuses required consent for services in home or alternative community settings; or if request for Mobile Crisis Intervention services originates from a hospital emergency department. 11. In those instances in which a youth is sent to a hospital emergency department (ED), Mobile Crisis Intervention mobilizes to the ED. The number of hospital-based interventions will be closely monitored to ensure that Mobile Crisis Intervention services are delivered primarily in community settings.

Quality Management (QM)	
	1. Mobile Crisis Intervention participates in all ESP network management, utilization management, and quality management initiatives and meetings.
Process Specifications	
Treatment Planning and Documentation	1. Telephonic requests for Mobile Crisis Intervention are triaged through the established phone triage system of the ESP team. All calls are answered by the ESP by a live staff person. An answering machine or answering service is not permitted, including those directing callers to call 911 or to go to a hospital emergency department (ED). Mobile Crisis Intervention arrives within one (1) hour of receiving a telephone request 24 hours a day, 365 days a year. For remote geographical areas, Mobile Crisis Intervention arrives within the usual transport time to reach the destination. 2. Mobile Crisis Intervention includes both a master's level clinician trained in working with children and families, with experience and/or training in nonviolent crisis intervention, crisis theory/crisis intervention, solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, and de-escalation techniques; and a paraprofessional or a Family Support and Training staff (Family Partner) experienced or trained in providing ongoing in-home crisis stabilization services and in navigating the behavioral health crisis response system who supports brief interventions that address behavior and safety; that mobilize to the home or other site where the youth is located (e.g., school, group home, residential program, etc.), 24 hours a day, 7 days a week. Between the hours of 10pm and 7am, Mobile Crisis Intervention staff may be on-call and dispatched by pager. 3. If Mobile Crisis Intervention determines that the situation warrants intervention by police or EMT personnel, Mobile Crisis Intervention calls and coordinates with them to ensure safety, and Mobile Crisis Intervention also responds in person to the location of the crisis.

	4. Mobile Crisis Intervention immediately works to de-escalate the situation and intervenes to ensure the safety of all individuals in the environment, utilizing the interventions and services listed under the "components of service" section above. 5. Mobile Crisis Intervention completes a comprehensive crisis assessment, including the elements listed under the "components of service" section above and engages in delivering crisis stabilization services. 6. To complete the crisis assessment and crisis intervention, Mobile Crisis Intervention seeks consent to speak with collateral contacts (e.g., ICC care coordinator, In-Home Therapy Services clinician, outpatient therapist, psychiatrist, DCF worker, etc.) and natural supports (e.g., friends, neighbors, extended family, etc.) to enlist their support in stabilizing the situation and developing/updating the set of Crisis Planning Tools and aftercare plan. 7. For youth enrolled in ICC, Mobile Crisis Intervention staff collaborates with the ICC provider to ensure coordination of care around the youth's Individual Care Plan (ICP) and, the set of Crisis Planning Tools, developed by the ICC care planning team. ICC providers are available 24/7 by phone or pager to answer calls from Mobile Crisis Intervention. Mobile Crisis Intervention coordinates with the ICC provider throughout the intervention. 8. The child psychiatrist or child trained Psychiatric Nurse Mental Health Clinical Specialist responds to Mobile Crisis Intervention staff requests for consultation within 15 minutes of the request, 24-hours per day, and 365 days per year. For urgent medication evaluations or urgent medication management appointments, the Mobile Crisis Intervention provider ensures face-to-face appointments with the youth's existing prescriber or with Mobile Crisis Intervention's psychiatric clinician within 48 hours. 9. If the crisis assessment indicates that placement outside of the home in an acute 24-hour behavioral health level of care (e.g., Crisis Stabilization setting, acute inpatient hospital, community based acute treatment (CBAT) setting, or intensive community based acute treatment (ICBAT) setting) is medically necessary, Mobile Crisis Intervention obtains authorization as needed; arranges transfer and admission to an appropriate facility; and consults with the receiving provider to assist the receiving provider to develop a plan for stabilizing the crisis that was addressed by the Mobile Crisis Intervention. 10. If the crisis assessment indicates that the youth is stable to remain in the community or current placement, Mobile Crisis Intervention obtains authorization for medically necessary community-based services and coordinates with the youth and family and the community-based service provides to ensure that the youth is receiving medically necessary services.

	11. If the youth is not already enrolled in ICC, Mobile Crisis Intervention may arranges a follow-up appointment with the ICC provider in the youth's service area and coordinates with the ICC provider for the following 7 days to ensure that the youth is receiving medically necessary services.
Discharge Planning and Documentation	1. For youth who remain in the community, Mobile Crisis Intervention will be in contact with the family for a period of up to 7 days following discharge from a mobile crisis intervention, to insure that the aftercare plan developed during the intervention has been implemented and will offer assistance as necessary in order to insure that the plan is implemented. 2. For youth with ICC, Mobile Crisis Intervention plans and coordinates *all* referrals for aftercare services with the ICC care coordinator. Mobile Crisis Intervention conducts at least one phone call or face-to-face meeting with the ICC provider and the family to facilitate the transition. 3. For youth with In-Home Therapy Services (or who Mobile Crisis Intervention has referred for In-Home Therapy Services), Mobile Crisis Intervention conducts at least one phone call or face-to-face meeting with the In-Home Therapy Services provider and the family to facilitate the transition. 4. Mobile Crisis Intervention facilitates access to Crisis Stabilization Services, ICC, In-Home Therapy Services, or other levels of care/covered services as medically necessary and ensures that families have established a connection with the services and supports identified through Mobile Crisis Intervention assessment and intervention. Mobile Crisis Intervention remains involved with the youth and his/her parent/guardian/caregiver(s) until aftercare services are established and work has begun with the identified aftercare provider(s). Simply making a referral for an aftercare service does not meet the criteria for ensuring that the youth and his/her parent/guardian/caregiver(s) have established a connection with a provider. If the parent or guardian declines aftercare supports and services, this must be clearly documented in the youth's medical record. 5. With required consent, the Mobile Crisis Intervention provider sends copies of the crisis assessment to all necessary providers as identified by the youth and parent/guardian/caregiver, including state agency, school, and juvenile justice personnel. With signed consent, a copy of any Crisis Planning Tools is shared with all individuals and/or providers as identified by the youth and family.

Adult Community Crisis Stabilization (CCS)

Providers contracted for this level of care will be expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers of this service and all contracted services will be held accountable to the "General" performance specifications,** located at the beginning of this section of the *MBHP Provider Manual*.

The adult **Community Crisis Stabilization (CCS)** program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less-restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18 – 21 under the Children's Behavioral Health Initiative (CBHI). Adult CCS provides a distinct level of care where primary objectives of the active multi-disciplinary treatment include restoration of functioning; strengthening the resources and capacities of the individual, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized risk management/safety plan; and linkage to ongoing, medically necessary treatment and support services. Adult CCS staff provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; psychiatric evaluation and medication management; peer-to-peer support; and mobilization of natural supports and community resources. CCS services are short-term, providing 23-hour observation and supervision, and continual re-evaluation.

This program is required to have a home-like, consumer-friendly, and comfortable environment that is conducive to recovery. CCS staff provides psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual's specific community. Guided by the treatment preferences of the individual, CCS staff actively involves family and other natural supports at a frequency based on individual needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. In the case of young adults who are involved with, or who are referred for, CBHI services – including ICC – CCS staff will accommodate and participate in team meetings.

Note that the primary differences between CCS and inpatient level of care is the acuity of the consumer, the unlocked setting, the level of psychiatry services, and an absence of immediate need for hospital-based diagnostic tests or general medical treatment. Admissions to the CCS occur 24/7/365 based on determinations made by mobile and site-based ESP staff. Discharges from the CCS occur 24/7/365, and discharge processes include efficiencies that maximize service capacity. Readiness for discharge is minimally evaluated on a daily basis, and the length of stay is expected to be very brief.

Criteria	
Admission Criteria	***All** of the **following criteria** (1-5) are necessary for admission to this level of care*: 1. The individual demonstrates active symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis, which requires and can reasonably be expected to respond to intensive, structured intervention within a brief period of time. 2. The individual demonstrates a significant incapacitating or debilitating disturbance in mood/thought/behavior interfering with ADLs to the extent that immediate stabilization is required. 3. Clinical evaluation of the individual's condition indicates recent significant decompensation with a strong potential for danger to self or others, and the individual cannot be safely maintained in a less restrictive level of care. 4. The individual requires 23-hour observation and supervision but not the constant observation of an inpatient psychiatric setting except where being used as an alternative to an inpatient level of care. 5. Clinical evaluation indicates that the individual can be effectively treated with short-term, intensive crisis intervention services and returned to a less intensive level of care within a brief time frame. ***One** of the following criteria (6-7) is also necessary for admission to this level of care:* 1. A less intensive or restrictive level of care has been considered or tried. 2. Clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care, and it is reasonably expected that a short-term crisis stabilization period in a safe and supportive environment will ameliorate the individual's symptoms.
Psychosocial, Occupational, and Cultural and Linguistic Factors	*These factors may change the risk assessment and should be considered when making level-of-care decisions.*
Exclusion Criteria	***Any** of the following criteria (1-6) is sufficient for exclusion from this level of care:* 1. The individual's psychiatric condition is of such severity that it can only be safely treated in an inpatient setting. 2. The individual's medical condition is such that it can only be safely treated in a medical hospital.

	3. The individual/family/guardian does not voluntarily consent to admission or treatment. 4. The individual can be safely maintained and effectively treated in a less intensive level of care. 5. The primary problem is social, economic, medical, or involving threat to others without a concurrent major psychiatric episode meeting criteria for this level of care. 6. Admission is being used for purposes of convenience or as an alternative to incarceration, protective services, or simply as respite or housing. 7. The individual does not have a disposition in place prior to discharge.
Continued Stay Criteria	***All*** *of the following criteria (1-11) are necessary for continuing treatment at this level of care:* 1. The individual's condition continues to meet admission criteria at this level of care. 2. The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate or is available. 3. Care is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan. 4. Treatment planning is individualized and age appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family/guardian or other support systems, social, occupational, educational, and interpersonal assessment with involvement unless contraindicated. Expected benefits from all relevant modalities, including family and group treatment, are documented and expected to improve the individual's condition in a relatively short period of time. 5. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. 6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident. 7. The individual is actively participating in treatment to the extent possible consistent with the individual's condition.

	8. Family, guardian, and/or custodian are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them. 9. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated. 10. There is documented active discharge planning beginning from admission. 11. There is documented active coordination of care with behavioral health providers, the PCP (primary care physician), and other services. If coordination is not successful, the reasons are documented.
Discharge Criteria	***Any*** *of the following criteria (1-6) is sufficient for discharge from this level of care:* 1. The individual's documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged at an alternate level of care. 2. The individual no longer meets admission criteria or meets criteria for a less or more intensive level of care. 3. The individual, family, guardian, and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment. 4. Consent for treatment is withdrawn by the individual and/or guardian, and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for an inpatient level of care. 5. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured, including focus on transitional services as deemed appropriate based on individual need. 6. The patient is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care.

ADULT COMMUNITY CRISIS STABILIZATION PROGRAM (CCS)

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers of this service and all contracted services will be held accountable to the "General" performance specifications,** located at the beginning of this section of the *MBHP Provider Manual*.

The adult **Community Crisis Stabilization program (CCS)** provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18-21 under the Children's Behavioral Health Initiative (CBHI). Adult CCS provides a distinct level of care where primary objectives of the active multi-disciplinary treatment include restoration of functioning; strengthening the resources and capacities of the individual, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized risk management/safety plan; and linkage to ongoing, medically necessary treatment and support services. Adult CCS staff provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; psychiatric evaluation and medication management; peer-to-peer support; and mobilization of natural supports and community resources. CCS services are short-term, providing 23-hour observation and supervision, and continual re-evaluation.

This program is required to have a home-like, consumer-friendly, and comfortable environment that is conducive to recovery. CCS staff provides psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual's specific community. Guided by the treatment preferences of the individual, CCS staff actively involves family and other natural supports at a frequency based on individual needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. In the case of young adults who are involved with, or who are referred for, CBHI services – including ICC – CCS staff will accommodate and participate in team meetings.

Note that the primary differences between CCS and inpatient level of care is the acuity of the consumer, the unlocked setting, the level of psychiatry services, and an absence of immediate need for hospital-based diagnostic tests or general medical treatment. Admissions to the CCS occur 24/7/365 based on determinations made by mobile and site-based Emergency Services Program (ESP) staff. Discharges from the CCS occur 24/7/365, and discharge processes include efficiencies that maximize service capacity. Readiness for discharge is minimally evaluated on a daily basis, and the length of stay is expected to be very brief.

Components of Service	
	1. The ESP operates a CCS 24/7/365 for adults ages 18 and older. Admissions and discharges occur 24/7/365. 2. The CCS provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. 3. The CCS is primarily used as a diversion from an inpatient level of care; however, the service may be used secondarily as a transition from inpatient services, if there is sufficient service capacity, and the admission criteria are met. ESP's outcomes are measured relative to the proportion of diversionary versus step-down admissions, with the expectation being that the majority are the former. 4. The CCS provides a distinct level of care where primary objectives of the active multi-disciplinary treatment include restoration of functioning; strengthening the resources and capacities of the individual, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized risk management/safety plan; and linkage to ongoing medically necessary treatment and support services. 5. CCS services are short-term, providing 23-hour observation and supervision, and daily re-evaluation and assessment of readiness for discharge. Through this process, the CCS strives to meet benchmarks for length of stay against which the program is measured by MBHP. 6. The CCS provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. 7. CCS services include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; psychiatric evaluation and medication management; peer-to-peer support; mobilization of and coordination with family and other natural supports, community treaters and other resources; psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual's specific community.

	8. Individuals who are admitted to the CCS must have a community-based disposition in place at the time of admission to the CCS. 9. The CCS is co-located with the ESP's community-based location in order to enhance service continuity and increase administrative efficiency to benefit those served. The overall ESP program operates in a fashion that ensures fluidity among ESP mobile services, site-based crisis services at the ESP community-based location, and the adult CCS and minimizes inconvenience to individuals in crisis. 10. The CCS has a home-like, consumer friendly, and comfortable environment that is conducive to recovery.
Staffing Requirements	
	1. The ESP maintains appropriate staffing patterns in the CCS to safely care for all persons 24/7/365. The ESP has a written plan that delineates, by shift, the number and qualifications of its staff, including psychiatry, nursing, clinicians, milieu workers, and other staff in relation to its average daily census. 2. The CCS provides awake staffing 24/7/365. 3. With the use of fluidly trained staff and cross-scheduling, programs demonstrate the ability to respond to varying levels of demand in the ESP's three primary three service components: adult and youth mobile services, the ESP community-based location, and the adult CCS program. All staff members are expected to share expertise in terms of clinical knowledge, service delivery (as appropriate for each discipline), and discharge planning. 4. The CCS utilizes a multidisciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use conditions of adults. 5. The medical and clinical care of the CCS is managed by the ESP medical director and the CCS nurse manager. The medical director is a board-certified or board-eligible psychiatrist, and the nurse is a registered nurse. 6. The ESP ensures adequate psychiatric coverage to ensure all CCS performance specifications are met. 7. The CCS has an attending psychiatrist who may be the ESP medical director or another psychiatrist. When the attending

	psychiatrist is not available, he/she designates a consistent substitute, as much as possible, to ensure that the Member receives continuity of care. The psychiatrist may delegate some psychiatric functions to a psychiatric nurse mental health clinical specialist. 8. The CCS ensures 24/7/365 availability of a psychiatric clinician, either a board-certified or board-eligible psychiatrist, or a psychiatric nurse mental health clinical specialist, including nights and weekends. The psychiatric clinician is available for a psychiatric phone consultation within 15 minutes of request and for a face-to-face evaluation within 60 minutes of request, when clinically indicated. 9. The CCS's psychiatric clinicians provide psychiatric assessment, medication evaluations, and medication management, and contribute to the comprehensive assessment and discharge planning. 10. The nurse manager has overall responsibility for the CCS and accountability to the ESP director. She/he fills physician orders; administers medication; takes vital signs; coordinates medical care; contributes to comprehensive assessment, brief crisis counseling, individualized crisis prevention planning, and provider psycho- education; and assists with discharge planning and care coordination. The nurse manager leads treatment team meetings, or assigns a staff member to do so. The nurse manager also supervises LPNs and other staff working in the CCS. The nurse manager is a full-time position and works first shift or business hours unless otherwise approved by MBHP. 11. Licensed practical nurse (LPN) staffing, appropriate to licensure level, assist the nurse manager with filling physician orders, administering medications, and monitoring vital signs. They also work with the bachelor's level staff in ensuring an environment that promotes safety, recovery, and treatment. They contribute to the assessment, individualized crisis planning, discharge planning, and care coordination. The ESP provides adequate LPN staffing to ensure that all performance specifications are met. This staffing is generally expected to include an LPN on second and third shift on weekdays and all three shifts on weekends for average size adult CCS programs, unless otherwise approved by MBHP. 12. Master's level clinicians are primarily responsible for conducting comprehensive assessments, brief crisis counseling, psycho-education, and treatment team functions as noted below. The ESP provides adequate master's level clinician staffing to ensure that all performance specifications are met. This staffing is generally

	expected to include a master's level clinician working at least one shift per day, unless otherwise approved by MBHP. 13. The CCS provides bachelor's level milieu staff, preferably who are also credentialed as Certified Peer Specialists (CPS). These staff ensure an environment that promotes safety, recovery, and treatment. They contribute to the assessment, individualized crisis planning, discharge planning, and care coordination. Those who are certified as a CPS also provide peer-to-peer support and psycho-education about rehabilitation and recovery. As resources and time permit, the adult CCS will also have access to the Certified Peer Specialists who primarily staff the ESP's community-based location. The ESP provides adequate bachelor's level milieu staffing, with CPS preferred, to ensure that all performance specifications are met. This staffing is generally expected to include a bachelor's level staff 24/7/365 for average size adult CCS programs, unless otherwise approved by MBHP. 14. All ESP staff participate in ongoing supervision appropriate to their discipline and level of training and licensing. For Certified Peer Specialists and Family Partners, this supervision includes peer supervision. 15. The ESP ensures that CCS staff are included in all appropriate ESP staff training, including training required in the ESP Performance Specifications.
Service, Community, and Collateral Linkages	
	1. With Member consent, treatment providers, family members, and other collaterals are contacted within 24 hours of admission. 2. In the case of young adults who are involved with, or who are referred for, CBHI services – including ICC – CCS staff will accommodate and participate in team meetings. 3. The CCS refers all pregnant, substance-abusing female MBHP Members to MBHP's Intensive Case Management (ICM) Program, as well as other MBHP Members as indicated. All such referrals are documented in the Member's medical record. 4. The CCS adheres to established program procedures for referral to a more restrictive, medically necessary behavioral health level of care when the patient is unable to be treated safely in the CCS. 5. The CCS adheres to established program procedures for determining the necessity of a referral to a hospital when a Member requires non-psychiatric medical screening or stabilization.

	6. The ESP and CCS maintain knowledge of, and relationships with, behavioral health levels of care and other resources to which the CCS makes referrals for aftercare. 7. CCS and other ESP management and direct care staff hold regular meetings and communicate on clinical and administrative issues to enhance continuity of care.
Process Specifications	
Assessment and Treatment Planning	1. The CCS ensures that a comprehensive assessment and initial treatment plan is completed, a multidisciplinary treatment team has been assigned, and that the treatment team has met to review the assessment and initial treatment plan within 24 hours of admission. 2. A psychiatric clinician conducts a psychiatric assessment, including a medication evaluation, of each individual within 24 hours of admission during weekdays. On weekends and holidays, a master's level clinician may alternatively conduct an assessment and review the assessment, including the current medication regimen, and initial CCS treatment plan, with a psychiatric clinician by phone within six hours of the admission. A psychiatric clinician then conducts a psychiatric assessment within 24 hours, i.e., on Monday for weekend admissions or the subsequent day for holiday admissions. Subsequent to the psychiatric assessment and medication evaluation, a psychiatric clinician provides ongoing, face-to-face assessment, stabilization, treatment, and medication management services to the Member during the duration of their stay, as indicated by the CCS treatment plan. 3. All consultations indicated in the CCS treatment plan should be ordered within 24 hours of admission and provided in a timely manner.
Stabilization and Treatment	1. Adult CCS staff provides 23-hour observation, supervision, and support, and daily re-evaluation and assessment of readiness for discharge. 2. The CCS staff engages Members in structured therapeutic programming seven days per week, including treatment activities designed to stabilize the individual; restore functioning; strengthen the resources and capacities of the individual, family, and other natural supports; prepare for timely return to a natural setting and/or least restrictive setting in the community; develop and/or strengthen an individualized risk management/safety plan; and link to ongoing, medically necessary treatment and support services.

	3. The CCS staff provides psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual's specific community. 4. Guided by the treatment preferences of the individual, CCS staff actively involves family and other natural supports at a frequency based on individual needs. 5. The CCS staff carefully coordinates treatment with existing and/or newly established treatment providers.
Disposition Planning and Risk Management/Safety Planning	1. Upon admission, the CCS: a. assigns a clinician or other appropriate staff to be responsible for risk management/safety planning, discharge planning, and ensuring a smooth transition to medically necessary services, if any; and b. documents all efforts related to these activities, including the individual's participation in discharge planning. 2. CCS staff confirms that, upon presentation to the ESP, the ESP clinician asked the individual, significant others accompanying him/her, and/or community providers as to the existence of an established risk management/safety plan, and/or accessed any risk management/safety plan on file at the ESP for the given individual. The CCS staff obtains the risk management/safety plan from the ESP clinician. 3. During the ESP intervention, the ESP clinician updates any existing risk management/safety plan or creates one with the individual. The plan includes the presenting problem, the specific problem to be addressed along with a treatment plan, preferred disposition plan, and the involvement of others who may be available to support the individual before or during crises (i.e., providers, agencies, significant others, and/or family members). The purpose of this plan is to expedite a client-focused disposition based on the experience gained from past treatment interventions. The CCS staff obtains the updated or newly created risk management/safety plan from the ESP clinician and updates it further during the course of treatment at the CCS. 4. Upon discharge from the CCS, the CCS staff provides a copy of the updated risk management/safety plan to the individual, and with consent, to family members, the ESP, continuing or new community treaters, and/or other collaterals. 5. The CCS schedules post-discharge appointments for Members as follows: within seven business days of discharge for outpatient services, if medically necessary; and within 14 business days of discharge for medication monitoring, if medically necessary.

Appendix III: Quality Indicators

Quality Indicators	*Quality Indicator Goal*
Intervention Location	
Adult	30% Community-based (70% ED)
Youth	60% Community-based (40% ED)

ED= hospital Emergency Department

Disposition	
Adult	70% Diversion (30% IP)
Youth	82% Diversion (18% IP)

IP= Inpatient Mental Health Diversion= all dispositions/levels of care other than Inpatient mental health

Response Time in Minutes	
All Ages, all locations	45 minutes, all locations
Adult, all locations	[redacted]
Youth, all locations	
All Ages, ED	
All Ages, Community	

Response Time contractual obligation = 60 minutes

Quality Indicators	*Quality Indicator Goal*
Response Time % within 60 Minutes	
All Ages, all locations	85% within 60 minutes, all locations
Adult, all locations	
Youth, all locations	
All Ages, ED	
All Ages, Community	

Response Time contractual obligation = 60 minutes

Appendix IV: Core Staffing Pattern

Position	FTEs by service component					
	ESP mgmt.	***Comm.-based location***	***Adult mobile***	***Child mobile***	***Adult CSU***	***Total***
Estimated encounters	n/a	1,065	1,597	710	1,526	4,898
ESP Director	1.0					1.0
QM/ RM Director	0.4					0.4
Program Manager				1.0		1.0
Clinical Supervisor		0.4	0.7			1.1
Psychiatry		0.3		0.2	0.3	0.8
Psychiatry After-Hours Adult Consult		x				
Psychiatry After-Hours Child Consult				x		
Nursing Manager RN					1	1
Nursing LPN					3.2	3.2
Certified Peer Specialist		1.0				1.0
BS w/CPS preferred			0.5			0.5
BS Milieu w/CPS pref.					4.2	4.2
Paraprofessional (Family Partner)				1.7		1.7
MS Triage Clinician		1.0				1.0
MS Clinicians		2.0			1.5	3.5
MS Clinician Mobile			3.5	1.7		5.2
Safety Staff		1.4		cu		1.4
Admin. Assistant	0.5	0.5			0.3	1.3
Total FTE	1.9	6.6	4.7	4.6	10.5	28.3

This is the staffing pattern included in the ESP cost projections for an average size ESP within the medium volume range. A medium volume ESP is one with volume ranging from approximately 3,000 to 6,000 encounters including MBHP, MassHealth FFS (non-MCO), Medicare/Medicaid, MassHealth MCOs and Shadow/Uninsured (Uninsured, DMH-only, and Medicare-only.) Of the 4 Southeast ESPs, one "small volume" ESP has smaller projected volume than a "mid volume ESP," and three "large volume" ESPs have greater projected volume.

- Positions - Those shaded would vary based on actual volume of each of the ESPs. The remaining positions would be expected to increase slightly for "large volume" ESPs over 6,000 encounters and decrease for the one "small volume" ESP, projected to be under 3,000.

Appendix V: Minimum and Suggested Compensation Levels

The following table identifies each ESP core staffing position and the corresponding minimum wage rate as required by M.G.L. c. 7 §54(2). The table also identifies the comparable DMH and Uniform Financial Report (UFR) titles that are associated with the core staffing positions. Uniform Financial Reports are annual reports filed with the Operational Services Division by Emergency Service Providers. Please note that the DMH and UFR titles are not a one-to-one comparison; they relate to the core staffing positions rather to each other. For example the comparable DMH title for an MS Clinician (see chart) is a Human Services Coordinator (C), while ESP providers have reported to the state that they employ people in eight (8) different classifications to perform work associated with MS Clinician core staffing position.

Although multiple UFR titles may be associated with a particular core staffing position, bidders are not required by the RFR to hire staff at particular UFR titles. It is up to the bidder to determine the qualifications necessary to fill ESP positions. If, however, a bidder chooses to fill a position that corresponds to one of the UFR titles listed, then the bidder must pay the corresponding minimum wage associated with that UFR title.

Please reference the UFR Audit and Preparation Manual for a description of UFR title descriptions: http://www.mass.gov/anf/docs/osd/ufr/ufr2015.pdf

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
ESP Director	Clinical Social Worker (D) Psychologist IV	Program Director (UFR Title 102)	$62,202.14
QM/ RM Director	Manager VI	Supervising Professional (UFR Title 104)	$52,399.08
Program Manager	Clinical Social Worker (D)	Program Function Manager (UFR Title 101)	$62,202.14
Clinical Supervisor	Clinical Social Worker (C) Human Services Coordinator (D)	Supervising Professional (UFR Title 104)	$52,399.08
Nursing Manager RN	Registered Nurse IV Registered Nurse V	N. Midwife, N.P., Psych N. , N.A., R.N. – MA (UFR Title 107)	$62,225.86
		R.N. – Non-Masters (UFR Title 108)	**$51,552.04**

[1] "the lesser of step one of the grade or classification under which the comparable regular agency employee is paid, or the average private sector wage rate for said position as determined by the executive office for administration and finance…."

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
Nursing RN	Registered Nurse II Community Psychiatric MH Nurse	R.N. – Non-Masters (UFR Title 108)	$51,552.04
Nursing LPN	Licensed Practical Nurse I Licensed Practical Nurse II	L.P.N. (UFR Title 109)	$40,513.20
Certified Peer Specialist	Mental Health Coordinator I	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS w/CPS preferred	Human Services Coord (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu	Mental Health Worker I Mental Health Worker II	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu w/ CPS preferred	Human Services Coordinator (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
Paraprofessional (Family Partner)	Mental Health Coordinator I	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
MS Triage Clinician	Human Services Coordinator (C) Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinicians	Human Services Coordinator (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinician Mobile	Human Services Coordinator (C) Clinical Social Worker (A/B) Clinical Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
Safety Staff	Mental Health Worker I	Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
Admin. Assistant	Administrative Assistant I Clerk III	Program Secretarial/ Clerical Staff (UFR Title 137)	$27,543.92

The following ESP Core Staffing Positions do not have substantially comparable DMH positions and, therefore, are not subject to the minimum wage requirement (the UFR position and salaries for these positions are included for reference only):

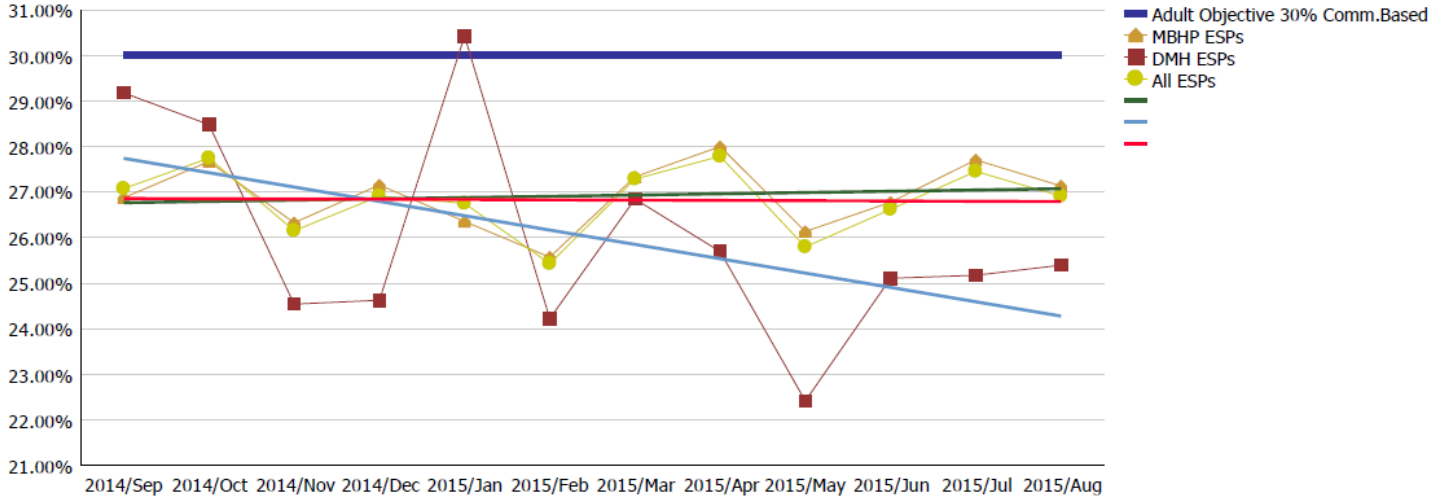
Additional ESP Core Staffing Positions	UFR Position	UFR Salary
Psychiatry	Physician & Psychiatrist (UFR Title 105 & 121)	$104,367.93
Psychiatry After-Hours Adult Consult	Physician & Psychiatrist (UFR Title 105 & 121)	$104,367.93
Psychiatry After-Hours Child Consult	Physician & Psychiatrist (UFR Title 105 & 121)	$104,367.93

Appendix VI: Current ESP Program-wide quality metrics

Below are performance dashboards highlighting the quality performance of the ESP program across all locations across both MBHP ESPs, DMH ESPs (southeast ESPs) and combined across all ESPs. These dashboards are current as of November 1, 2015.

Community - based Interventions

Adults 21+, Contracted Payers, Sep 2014 - Aug 2015



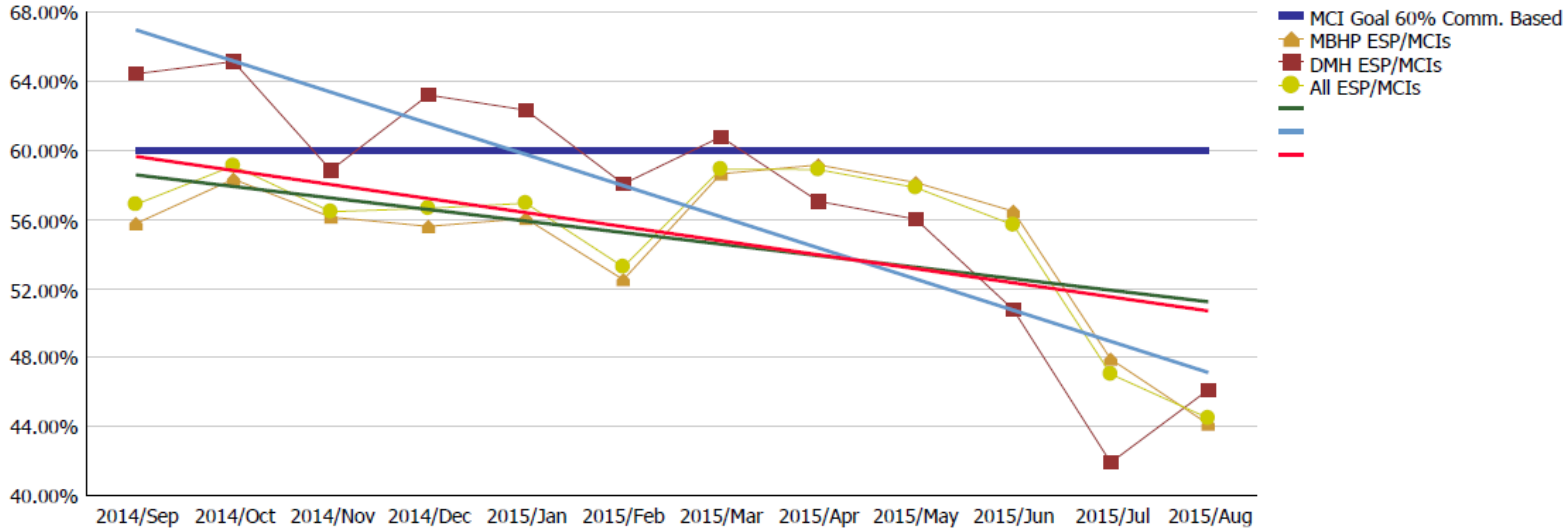
	2015/Jul	2015/Aug	FY 2016 YTD AVG
FY' 2016			
MBHP ESPs	27.71%	27.14%	27.46%
DMH ESPs	25.17%	25.40%	25.29%
All ESPs	27.46%	26.91%	27.21%

Summary:

MBHP ESPs community-based interventions for adults are trending up and range from 26% to 28%, FY' 2016 avg 27%.
DMH ESPs community-based interventions are trending down and range from 22% to 30%, FY' 2016 avg 25%.
All ESPs community-based interventions are trending down and range from 25% to 28%, FY' 2016 avg 27%.

Community - based Interventions

MCI Youth 0-20, MBHB ESP/MCIs, DMH ESP/MCIs, All ESP/MCIs, Contracted Payers, Sep 2014 - Aug 2015



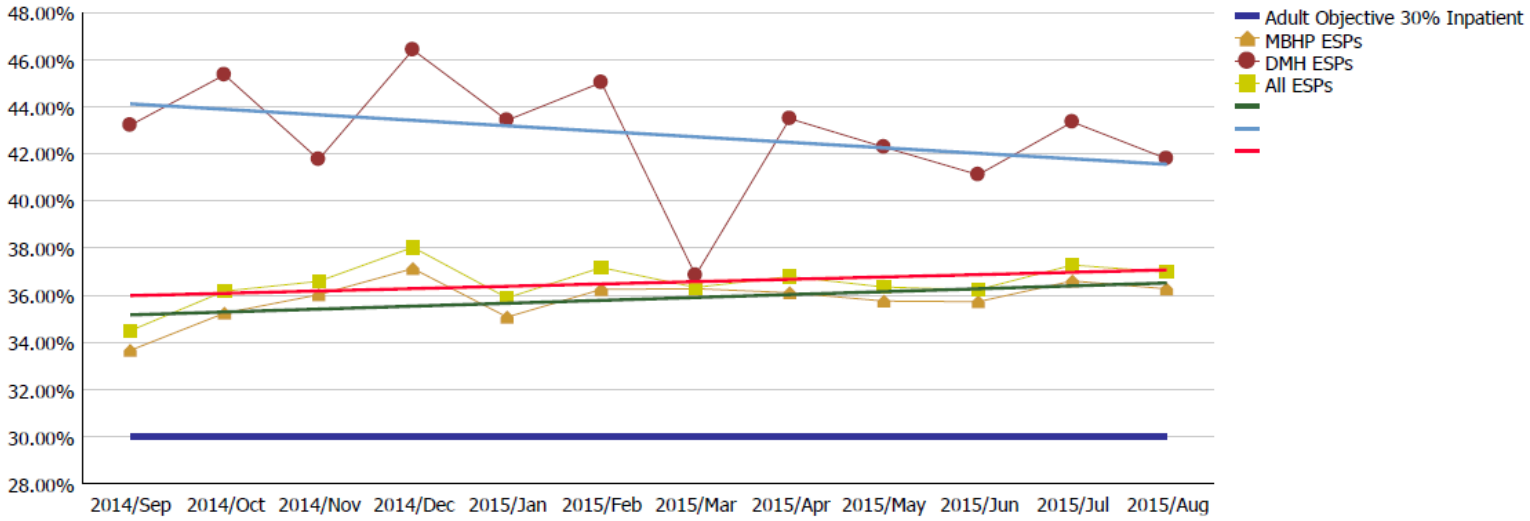
FY' 2016

	2015/Jul	2015/Aug	FY 2016 YTD AVG
MBHP ESP/MCIs	47.90%	44.14%	46.18%
DMH ESP/MCIs	41.90%	46.12%	44.06%
All ESP/MCIs	47.03%	44.48%	45.84%

Summary:

MBHP ESP/MCIs community-based interventions are trending down & range from 44% to 59%; FY' 2016 avg 46%
DMH ESP/MCIs community-based interventions are trending down & range from 42% to 65%; FY' 2016 avg 44%
All ESP/MCIs community-based interventions are trending down & range from 44% to 59%; FY' 2016 avg 46%

Disposition
by CCS, Other Diversionary Services, and Inpatient
Adults 21+, Contracted Payers, Sep 2014 - Aug 2015
Inpatient

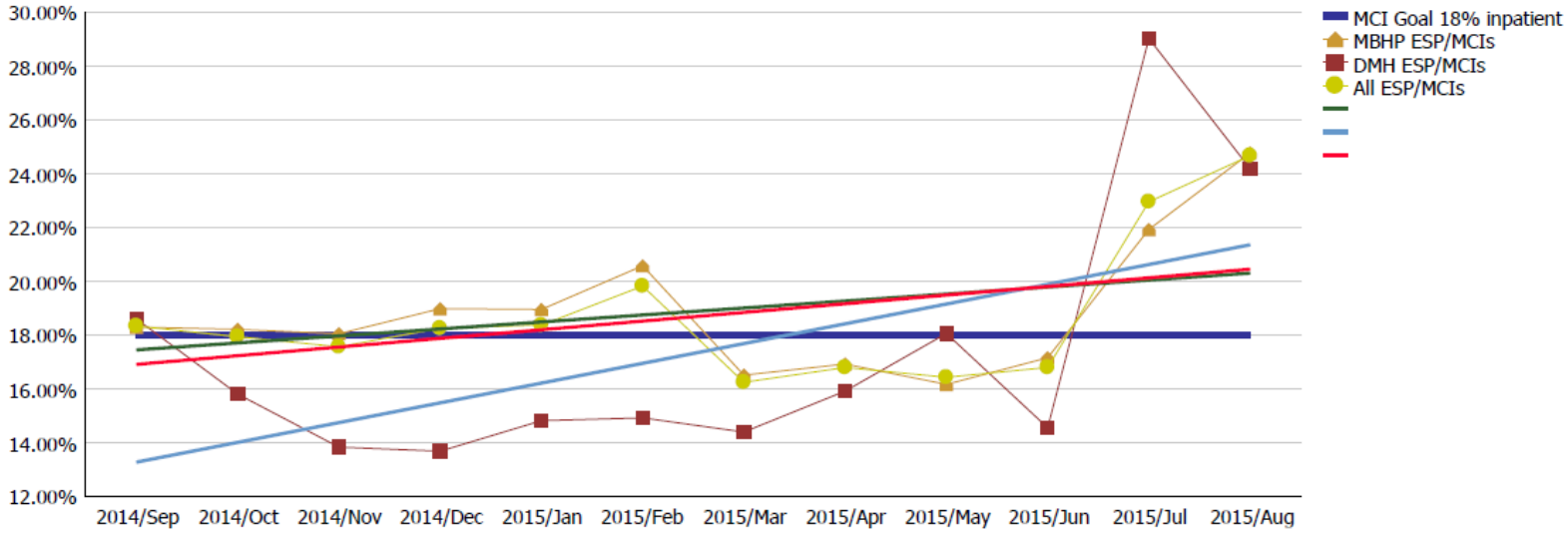


FY' 2016

	2015/Jul	2015/Aug	FY2016 YTD AVG
MBHP ESPs	36.61%	36.27%	36.46%
DMH ESPs	43.36%	41.80%	42.56%
All ESPs	37.28%	36.99%	37.15%

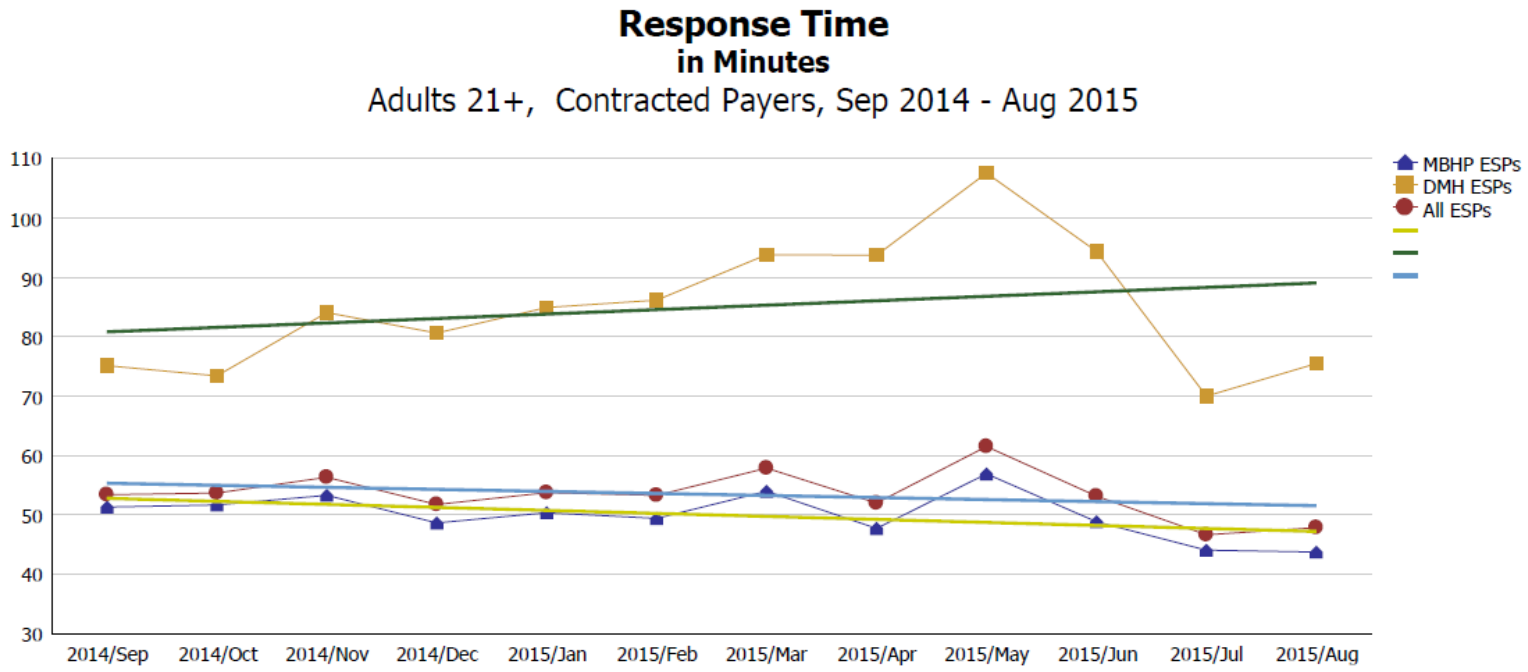
Summary:
MBHP ESPs Inpatient dispositions for adults are trending up & range from 34% to 37%; FY' 2016 avg 36%.
DMH ESPs Inpatient dispositions for adults are trending down & range from 37% to 46%; FY' 2016 avg 43%.
All ESPs Inpatient dispositions for adults are trending up & range from 34% to 38%; FY' 2016 avg 37%.

Disposition
by ICBAT/CBAT, Other Diversionary Services and Inpatient
MCI Youth 0-20, MBHB ESP/MCIs, DMH ESP/MCIs, All ESP/MCIs, Contracted Payers, Sep 2014 - Aug 2015
Inpatient



		2015/Jul	2015/Aug	FY2016 YTD AVG
FY' 2016	MBHP ESP/MCIs	21.94%	24.79%	23.24%
	DMH ESP/MCIs	29.05%	24.20%	26.57%
	All ESP/MCIs	22.97%	24.68%	23.77%

Summary:
MBHP ESP/MCIs Inpatient dispositions are trending up & range from 16% to 25%; FY' 2016 avg 23%
DMH ESP/MCIs Inpatient dispositions are trending up & range from 14% to 29%; FY' 2016 avg 27%
All ESP/MCIs Inpatient dispositions are trending up & range from 16% to 25%; FY' 2016 avg 24%



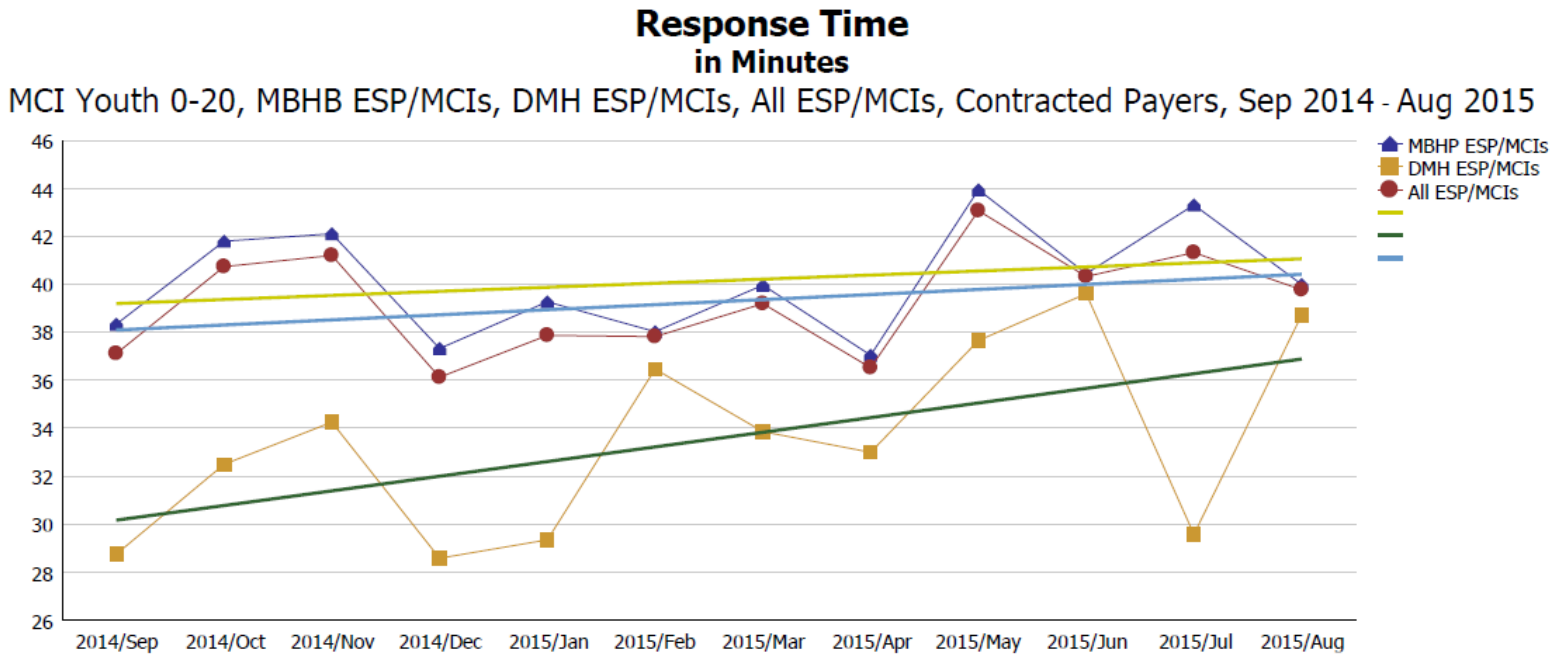
FY' 2016

	2015/Jul	2015/Aug	FY2016 YTD AVG
MBHP ESPs	44	44	44
DMH ESPs	70	76	73
All ESPs	47	48	47

Summary:

MBHP ESPs response times for adults are trending down and ranges from 44 min to 57 min , FY' 2016 avg is 44 min.
DMH ESPs response times for adults are trending up and ranges from 70 min to 108 min , FY' 2016 avg is 73 min.
All ESPs response times for adults are trending down and ranges from 47 min to 62 min, FY' 2016 avg 47 min.

Note: Contractual requirement is a response time of 60 minutes or less



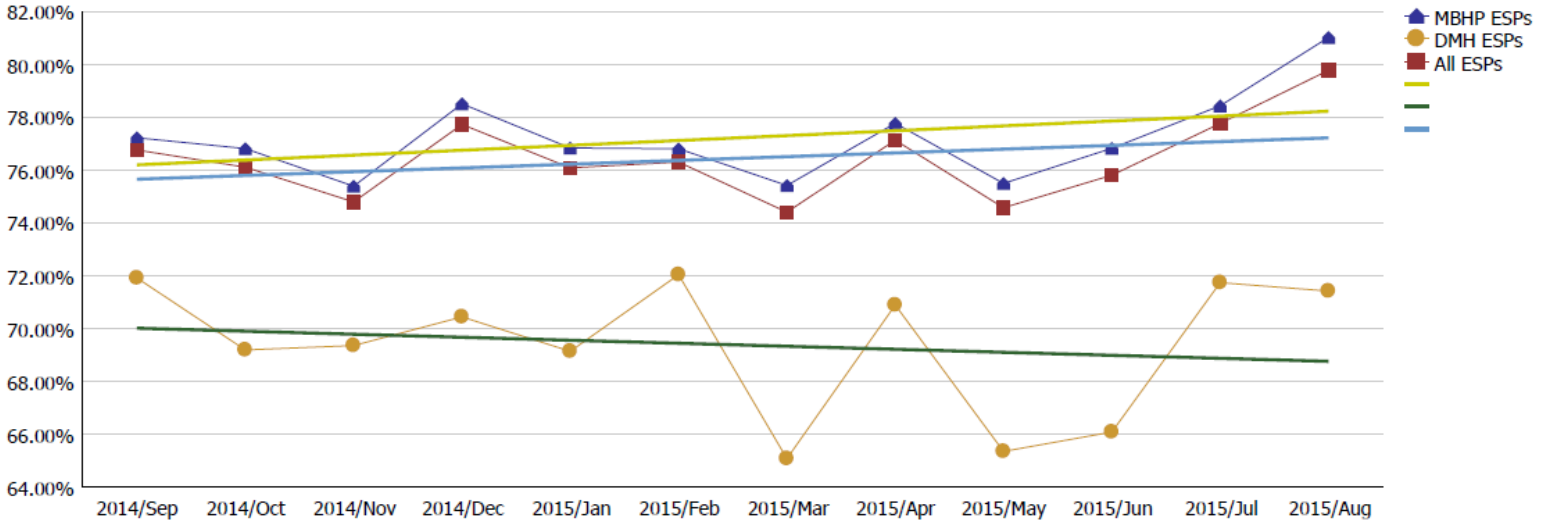
FY' 2016

	2015/Jul	2015/Aug	FY2016 YTD AVG
MBHP ESP	43	40	42
DMH ESP	30	39	34
ALL ESPs	41	40	41

Summary:

MBHP ESP/MCIs response time is trending up and ranges from 37 to 44; FY' 2016 avg 42
DMH ESP/MCIs response time is trending up and ranges from 29 to 40; FY' 2016 avg 34
All ESP/MCIs response time is trending up and ranges from 36 to 43; FY' 2016 avg 41

Response Time
Percent Within 60 minutes
Adults 21+, Contracted Payers, Sep 2014 - Aug 2015



FY' 2016

	2015/Jul	2015/Aug	FY2016 YTD AVG
MBHP ESPs	78.46%	81.06%	79.60%
DMH ESPs	71.75%	71.43%	71.58%
All ESPs	77.79%	79.81%	78.70%

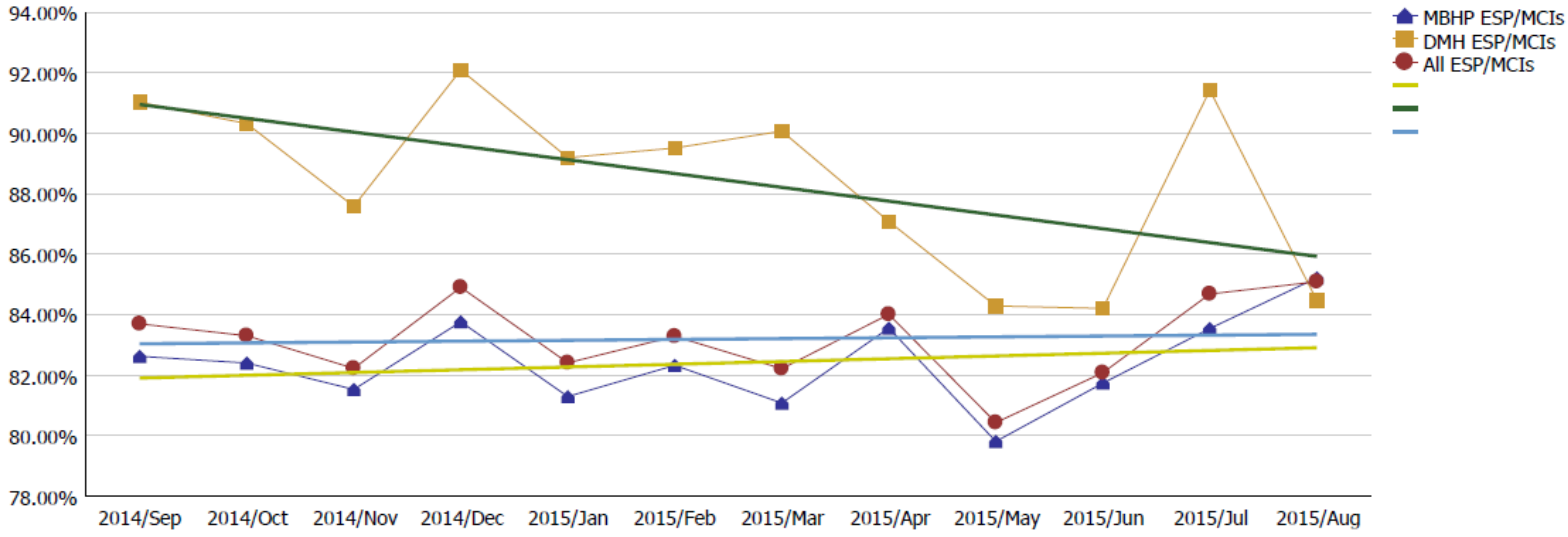
Summary:

The average response time of MBHP ESPs within 60 min is trending up , MBHP ESPs response times range from 75.41% to 81.06%; FY' 2016 avg is 80%.

The average response time of DMH ESPs within 60 min is trending down, DMH ESPs response times range from 65.07% to 72.05%; FY' 2016 avg is 72%.

The average response time of All ESPs within 60 min is trending up , All ESPs response times range from 74.42% to 79.81%; FY' 2016 avg is 79%.

Response Time
Percent Within 60 minutes
MCI Youth 0-20, MBHB ESP/MCIs, DMH ESP/MCIs, All ESP/MCIs, Contracted Payers, Sep 2014 - Aug 2015



FY' 2016

	2015/Jul	2015/Aug	FY2016 YTD AVG
MBHP ESP	83.55%	85.22%	84.32%
DMH ESP	91.43%	84.47%	87.88%
All ESPs	84.69%	85.09%	84.88%

Summary:

The average response time of MBHP ESPs within 60 min is trending up , MBHP response times range from 79.81% to 85.22%; FY' 2016 avg 84%

The average response time of DMH ESPs within 60 min is trending down, DMH response times range from 84.21% to 92.10%; FY' 2016 avg 88%

The average response time of All ESPs within 60 min is trending up , All ESPs response times range from 80.44% to 85.09% ; FY' 2016 avg 85%

Appendix VII: MBHP Contract – Amendments 1-19 Incorporated

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Contract for

The MassHealth PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
1 ASHBURTON PLACE
BOSTON, MA 02108

and

THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP
1000 WASHINGTON STREET
BOSTON, MA 02118

September 30, 2012

This Contract, entered into effective this ____ day of _____, 2012, is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS," or "MassHealth") and the Massachusetts Behavioral Health Partnership (MBHP), a general partnership under ValueOptions, Inc., of Norfolk, VA, with principal offices at 1000 Washington Street, Boston, MA 02118 ("Contractor").

WHEREAS, The Massachusetts Executive Office of Health and Human Services (EOHHS) is the single state agency responsible for administering the Medicaid program and the state's Children's Health Insurance Program (CHIP) within Massachusetts (collectively, MassHealth), pursuant to M.G.L. c.118E, Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. § 1397aa et seq.), and other applicable laws and waivers; and

WHEREAS, EOHHS seeks and the Contractor agrees to provide innovative, cost-effective, high-quality care management services, network management services, quality management activities and comprehensive Behavioral Health Services for certain MassHealth members, including but not limited to a Care Management Program for individual Enrollees with complex medical and/or behavioral health conditions; and

WHEREAS, EOHHS seeks and the Contractor agrees to continue and enhance recovery, resiliency, family-centered and strength-based approaches to the provision of care; and

WHEREAS, EOHHS seeks and the Contractor agrees to develop a robust medical and behavioral health system of care, that is integrated both at both a the system level and at the individual level in order to improve health care outcomes for MassHealth members; and

WHEREAS, EOHHS seeks to implement the Commonwealth's payment reform initiatives to promote the most efficient and effective use of resources; and

WHEREAS, the parties agree that the rates and terms stated herein are subject to the approval of the federal Centers for Medicare and Medicaid Services (CMS);

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, the Contractor and EOHHS agree as follows:

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DEFINITIONS AND ACRONYMS

Definitions

The following terms appearing capitalized throughout this Contract and its Appendices have the following meanings, unless the context clearly indicates otherwise.

N.B.: The word “day,” whenever it appears in these documents, refers to a calendar day unless otherwise specified.

Adjustment – a compromise between the Contractor and the Covered Individual reached at any time after an Adverse Action but before the BOH issues a decision on a BOH Appeal.

Administrative Component of the BH Covered Services Capitation Rate – a Per-Member (Covered Individual) Per-Day rate paid by EOHHS to the Contractor for the administration of the PCC Plan’s BHP.

Adverse Action – the following actions or inactions by the Contractor:

(1) the failure to provide MassHealth Covered Services in a timely manner in accordance with the waiting time standards in **Section 3.1.G.8**;

(2) the denial or limited authorization of a requested service, including the determination that a requested service is not a MassHealth Covered Service;

(3) the reduction, suspension, or termination of a previous authorization for a service;

(4) the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue; provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:

- failure to follow prior authorization procedures;
- failure to follow referral rules;
- failure to file a timely Claim; and

(5) the failure to act within the timeframes in **Section 4.2.A.2.e** for making authorization decisions.

Alternative Lock Up Programs -- Human service agencies contracted with the Commonwealth of Massachusetts Department of Children and Families to provide a temporary placement resource for the Commonwealth of Massachusetts state and local police departments in their efforts to comply with federal and state regulations regarding the placement of juveniles in their custody for either status or non-violent delinquent offenses.

Annual Payment Amount for the Care Management Program – the amount equal to the sum of all the Engagement PPPM payments plus the sum of all CMP outcomes measurements incentive payments plus any amount that the Contractor includes for the CMP in the Administrative Component of the BH Covered Services Capitation Rate.

Applied Behavioral Analysis – A MassHealth service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning.

Behavioral Health (BH) – mental health and substance abuse.

Behavioral Health Clinical Assessment – the comprehensive clinical assessment of a Covered Individual that includes a full bio-psycho-social and diagnostic evaluation that informs Behavioral Health treatment planning. It is performed when a Covered Individual begins Behavioral Health treatment and is reviewed and updated during the course of treatment. Behavioral Health Clinical Assessments provided to Covered Individuals under the age of 21 require the use of the CANS Tool to document and communicate assessment findings.

Behavioral Health Covered Services – the services the Contractor is responsible for providing to Covered Individuals, as applicable and as described in **Appendix A-1**.

Behavioral Heath Covered Services Capitation Rate – a Per-Member (Covered Individual) Per-Day (PMPD) and a Per-Member (Covered Individual) Per-Month rate paid by EOHHS to the Contractor for the provision of BH Covered Services to Covered Individuals. This actuarially sound capitation rate, as described in 42 CFR 438.6, is developed in accordance with generally accepted actuarial principles and practices, is appropriate for the populations to be covered and the services to be furnished under the Contract, has been certified as meeting the requirements of 42 CFR 438.6 by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board, and has been approved by the Centers for Medicare and Medicaid Services (CMS).

Behavioral Health Network Provider (or **Network Provider**) – a provider that has contracted with the Contractor to provide Behavioral Health Covered Services under the BH Program.

Behavioral Health Program (BHP) – that portion of the Contract related to the administration, coordination, delivery and management of the BH Covered Services described in **Appendix A-1**.

BH Rate – the portion of the CPCP Rate paid to Tier 2 or Tier 3 PCPR Providers by the Contractor for Behavioral Health Covered Services provided to PCC Panel Enrollees. The BH Rate is a Per-Member Per-Month amount specific to a Participating Site.

Board of Hearings (BOH) – the Board of Hearings within the Executive Office of Health and Human Services' Office of Medicaid.

BOH Appeal – a written request to the BOH, made by a Covered Individual or Appeal Representative who has been authorized by a Covered Individual in writing to act on his/her behalf with respect to a BOH Appeal, to review the correctness of an Internal Appeal decision by the Contractor.

Care Coordination – management of care activities performed by the Contractor on behalf of a Covered Individual to improve health outcomes and may include medical, behavioral health, and pharmacy management and medication reconciliation among providers, agencies, and community social supports, as described in **Section 5.3**.

Care Management Program (CMP) – the administration and provision of certain clinical management and support activities to certain Enrollees and Providers, as described in **Section 6.2**.

Care Team – a group of individuals led by the care coordinator or care manager, including the Covered Individual, the Primary Care Clinician (PCC), and any other medical or behavioral health provider, case manager from another state agency, and any family member or other individual requested as part of the team by the Covered Individual.

Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees states' Medical Assistance programs and states' Children Health Insurance Programs (CHIP) under Titles XIX and XXI of the Social Security Act and waivers thereof.

Child and Adolescent Needs and Strengths (CANS) Tool – a tool that provides a standardized way to organize information gathered during Behavioral Health Clinical Assessments and during the discharge planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services. A Massachusetts version of the CANS Tool has been developed and is intended to be used as a treatment decision support tool for Behavioral Health Providers serving MassHealth Members under the age of 21.

CANS IT System – a web-based application accessible through the EOHHS Virtual Gateway into which Behavioral Health Providers serving MassHealth Members under the age of 21 will input: (1) the information gathered using the CANS Tool; and (2) the determination whether or not the assessed Member is suffering from a Serious Emotional Disturbance.

Children's Behavioral Health Initiative (CBHI) – an interagency undertaking by EOHHS to strengthen, expand and integrate Behavioral Health services for MassHealth Members under the age of 21 into a comprehensive system of community-based, culturally competent care.

Children's Behavioral Health Initiative Services (or **CBHI Services)** – any of the following services: Intensive Care Coordination (ICC), Family Support and Training, In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) and Therapeutic Mentoring Services, In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support), and Mobile Crisis Intervention.

Children in the Care and/or Custody of the Commonwealth – children who are Covered Individuals and who are in the care or protective custody of the Department of Children and Families (DCF), or in the custody of the Department of Youth Services (DYS). Children in the Care and/or Custody of the Commonwealth are eligible to receive services through the BHP without being required to enroll in the PCC Plan; however, any such children who are enrolled in the PCC Plan are considered Enrollees.

Claim – a bill for services, a line item of service, or all services for one Covered Individual or Uninsured Individual.

Clean Claim – a Claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating from the Contractor's claims system. It does not include a Claim from a Provider who is under investigation for fraud or abuse or a Claim under review for Medical Necessity.

Clinical Criteria – the criteria used to determine the most clinically appropriate and necessary Level of Care, and amount, duration, or scope of services, to ensure the provision of Medically Necessary Behavioral Health Covered Services.

Community Service Agency (CSA) – a community-based Behavioral Health provider organization whose function is to facilitate access to the continuum of Behavioral Health services by providing an organized pathway to care for children and families where the child is referred for Intensive Care Coordination. A primary mechanism through which CSAs serve this function is as the provider of Intensive Care Coordination and Family Support and Training Services, which are defined as a BH Covered Service.

Comprehensive Primary Care Payment (CPCP) – a risk-adjusted, per-PCC Panel Enrollee, per-month payment to a PCPR Provider for a defined set of Primary Care services and Behavioral Health Covered Services.

CPCP Rate – the rate paid to PCPR Providers for provision of the CPCP Covered Services.

CPCP Covered Services – the set of services specified in **Appendix J-5.**

CPCP Tier – one of three options for the CPCP, each of which includes a different set of services.

Continuing Services – disputed BH Covered Services provided by the Contractor to a Covered Individual notwithstanding the Date of Action, following an Adverse Action that terminates, modifies or denies BH Covered Services that the Covered Individual is receiving at the time of the Adverse Action, pending the resolution of an Internal Appeal and/or a BOH Appeal.

Contract – this agreement executed between the Contractor and EOHHS pursuant to EOHHS's Request for Responses (RFR) for the PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs, issued in 2011, and any amendments thereto. The Contract incorporates by reference all attachments and appendices thereto, including the Contractor's response to the RFR.

Contractor – the entity that executes this Contract with EOHHS.

Contract Year – except for Contract Year One, the 12-month period beginning on July 1 of each year.

Contract Year One – the period that begins on the Service Start Date and ends on June 30, 2013.

Coverage Type -- a defined scope of medical services, other benefits, or both, that are available to individuals who meet specific MassHealth eligibility criteria. Coverage Types for this Contract include MassHealth Standard, Basic, CommonHealth, Family Assistance, Essential, and CarePlus. See 130 CMR 450.105 and 130 CMR 505.008 for an explanation of each Coverage Type.

Covered Individuals – MassHealth Members who are eligible to receive Behavioral Health Covered Services under the BHP, including PCC Plan Enrollees, MFP Waiver Participants, Children in the Care and/or Custody of the Commonwealth and children in MassHealth Standard or CommonHealth with other health insurance.

Credentialing Criteria – criteria that a Provider must meet to be qualified as a Network Provider.

Crisis Prevention Plan – a plan directed by the Covered Individual, or in the case of Covered Individuals under age 18, their legal guardian, designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. The Crisis Prevention Plan provides a thorough checklist of the triggers that may lead to or escalate a psychiatric crisis. The plan also includes potential clinical presentations and a preferred disposition and treatment plan for each of these presentations as well as the Covered Individual's preferences with respect to involvement of the Covered Individual, his/her family and other supports, such as behavioral health providers, community social service agencies, and natural community supports. With the Covered Individual's consent, the plan may be implemented by an ESP, other BH Network Provider, the PCC, the staff from the CSA, or another provider. This type of plan may also be referred to as a Wellness Recovery Action Plan (WRAP) for adults with Severe and Persistent Mental Illness (SPMI), and a Risk Management Safety Plan for children with Severe Emotional Disturbance (SED) and their families.

Date of Action – the effective date of an Adverse Action.

Department of Mental Health (DMH) – the department within the Massachusetts Executive Office of Health and Human Services designated as the Commonwealth's mental health authority pursuant to M.G.L. c. 19 and M.G.L. c. 123, et seq.

DMH Administrative Budget – the total dollar amount paid to the Contractor for the DMH Specialty Programs Administrative Compensation Rate, covering the administrative costs for ESP for Uninsured Individuals and persons covered by Medicare only, Forensic Evaluations, and MCPAP.

DMH Case Management – a service operated by DMH which is performed in accordance with DMH regulations for DMH Clients. DMH Case Management includes those services enumerated in 104 CMR 29.00.

DMH Clients – for purposes of this Contract, individuals whom EOHHS identifies to the Contractor as being eligible for and recipients of DMH services.

DMH Service Authorization – the process by which a Member is found to be eligible and approved for a service provided through DMH.

DMH Specialty Programs – programs the Contractor manages under the Contract on behalf of DMH, including the Emergency Services Program (ESP) for Uninsured Individuals and persons covered by Medicare only, the Massachusetts Child Psychiatry Access Project (MCPAP), and Forensic Evaluations.

DMH Specialty Programs Administrative Compensation Rate – a dollar amount to be paid monthly by EOHHS to the Contractor for the administration of ESP Services for Uninsured Individuals including persons covered by Medicare only, the MCPAP program, and the Forensic Evaluation program.

DMH Specialty Programs Total Compensation Rate Payment – the amount paid by EOHHS to the Contractor pursuant to **Section 10.9** and **10.10**, which includes the DMH Specialty Programs Services Compensation Rate Payment plus the DMH Specialty Programs Administrative Compensation Rate.

DMH Specialty Programs Service Compensation Rate – the amount paid by EOHHS to the Contractor pursuant to **Section 10.10** for the provision of DMH Specialty Programs services.

Designated Forensic Professional – a physician or psychologist designated by the Department of Mental Health as qualified to perform a clinical assessment of the mental status of a prisoner and provide recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment. See M.G.L. c. 123, § 18(a).

Direct Costs – Contractor-incurred costs directly related to the administration of the Contract. Direct Costs include but are not limited to: clinical, administrative, technical and support staff assigned to the Contract; and related administrative expenses. Direct Costs do not include federal and state taxes except sales tax and taxes attributable to personnel.

Direct Service Reserve Account (DSRA) – an interest-bearing trust account maintained by the Contractor in a bank located in Massachusetts and approved by EOHHS in accordance with the provisions of the Contract, into which payments to the Contractor are deposited when paid by EOHHS.

Discharge Planning – the evaluation of a Covered Individual's medical and Behavioral Health care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one Level of Care to another Level of Care, including referral to appropriate services.

Dual Diagnosis – co-occurring mental health and substance abuse conditions.

Earnings – the Contractor's revenue or profit related DMH Specialty Programs Administrative Budget of this Contract. Earnings are an agreed-upon amount of the DMH Specialty Programs Administrative Budget, as described in **Section 10** and **Appendix H-1.**

Effective Date of Enrollment – as of 12:01 a.m. on the first day, as determined by EOHHS, on which the Contractor is responsible for providing Behavioral Health Covered Services, to an Enrollee and as reflected in the HIPAA 834 Outbound Enrollment File.

Eligible Days – depending on the context, the total number of days in a month for which Covered Individuals were eligible for Behavioral Health Covered Services, as determined by EOHHS; or the total number of days in a month for which Enrollees were eligible for the PCC Plan, as determined by EOHHS.

Eligibility Verification System (EVS) – EOHHS's computerized system for verifying MassHealth Member eligibility.

Emergency – a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a beneficiary or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act. (42 U.S.C. § 1395dd(e)(1)(B).)

Emergency Service Programs (ESPs) – the Network Providers, identified in **Appendix A-3**, that provide ESP Services as described in **Appendix A-1, Part III** in accordance with the requirements of the Contract.

ESP Amount – the total amount paid for ESP Services provided under the Contract to Uninsured Individuals and persons covered by Medicare only.

Emergency Services – MassHealth Covered Services that are furnished to a Covered Individual by a provider qualified to furnish such services under Title XIX of the Social Security Act, and that are needed to evaluate or stabilize a Covered Individual's Emergency medical condition.

Encounter – a professional contact between a patient and a provider who delivers health care services.

Engagement – in-person or telephonic encounter(s) with a Participant, for the purposes of completing a comprehensive health assessment, and creating and implementing an Individual Care Plan (ICP).

Engagement Rate – the number of Participants in the Care Management Program as a percent of the total number of Enrollees for whom the Contractor conducts outreach for the CMP.

Engagement Target – the minimum projected number of Enrollees in each Tier the Contractor is required to successfully enroll in the CMP each Contract Year.

Enrollee – a person determined eligible for MassHealth who is enrolled in the PCC Plan, either by choice or by assignment by EOHHS.

Enrollee Days – the sum of the number of days each Enrollee is enrolled in the PCC Plan.

Enrollment Broker – the EOHHS-contracted entity that provides MassHealth Members with assistance in enrollment into MassHealth Managed Care plans, including the PCC Plan.

EPSDT Periodicity Schedule – the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical and Dental Protocol and Periodicity Schedules that appears in Appendix W of all MassHealth provider manuals and is developed and periodically updated by MassHealth in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts DPH, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children's health. The Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Estimated Administrative Payment – a prospective monthly payment made by EOHHS to the Contractor for the administration of the BHP, based on an approximation of the number of Covered Individuals eligible for services under the Contract for that month multiplied by the applicable PMPD Administrative Component of the BH Capitation Rate.

Estimated Capitation Payment (ECP) – a prospective monthly payment made by EOHHS to the Contractor, based on an approximation of the number of Covered Individuals eligible for services under the Contract for that month multiplied by the applicable PMPD Capitation Rate. The payment is made regardless of whether the Covered Individual receives services during the period covered by the payment.

Estimated PCC Plan Management Support Services Payment – a prospective monthly payment made by EOHHS to the Contractor, based on an approximation of the number of Enrollees in the PCC Plan multiplied by the PMPD PCC Plan Support Services Rate.

Executive Office of Health and Human Services (EOHHS) – the executive agency within Massachusetts that is the single state agency responsible for the administration of the MassHealth program (Medicaid), pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto.

Expected External Service Provision Adjustment (EESPA) – a factor determined by EOHHS for use in calculating the CPCP, to reflect PCPR Panel Enrollees' receipt of CPCP Covered Services from health care providers other than the Contractor's Network Providers or certain Voluntary Pooled PCPR Providers.

External Quality Review Activities (EQR Activities) – activities performed by an entity with which EOHHS contracts in accordance with 42 CFR 438.358.

External Quality Review Contractor (EQR Contractor) – the entity with which EOHHS contracts to perform External Quality Review Activities.

Federal Financial Participation (FFP) – the federal share of the costs associated with states' administration of entitlement programs such as the Medicaid program.

Forensic Evaluation Services – a clinical assessment of the mental status of a prisoner, performed by a physician or psychologist designated by the Department of Mental Health as qualified to perform such examination in accordance with M.G.L. c. 123, § 18(a). Such examination shall including recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment, if so indicated.

Grievance – any expression of dissatisfaction by a Covered Individual or Appeal Representative about any action or inaction by the Contractor other than an Adverse Action. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of the Contractor, or failure to respect the Covered Individual's rights.

Health Care Acquired Conditions (HCACs) – conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886 (d)(4)(D)(iv) of the Social Security Act (SSA)(as described in Section 1886(d)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Healthcare Effectiveness Data and Information Set (HEDIS) – a standardized set of health plan performance measures developed by the National Committee for Quality Assurance (NCQA) and utilized by EOHHS and other purchasers and insurers.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – federal legislation (Pub. L. 104-191, as amended), enacted to improve the continuity of health insurance coverage in group and individual markets, combat waste, fraud, and abuse in health insurance and health-care delivery, simplify the administration of health insurance and protect the confidentiality and security of individually identifiable health information.

Health Needs Assessment – a tool that identifies and quantifies an Enrollee's physical and Behavioral Health status and needs based on morbidity and mortality risk, derived from the collection and review of demographic, physical and Behavioral Health and lifestyle information.

Health Safety Net – unpaid hospital charges, as defined in M.G.L. c. 118G, for Medically Necessary services provided to: (1) patients deemed financially unable to pay, in whole or in part, for their care; (2) uninsured patients who receive Emergency care for which the costs have not been collected after reasonable efforts; or (3) patients in situations of medical hardship where major expenditures for health care have been depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services will be unpaid.

Hold Harmless Payment – a payment made by the Contractor to PCPR Providers as compensation in the case where PCPR Provider incurs costs in excess of those compensated for by the CPCP, as calculated in Section 4.1 of the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract (**Appendix J-1**).

Homeless – individuals who lack regular, fixed, and adequate nighttime residence, and who, on a temporary or permanent basis, have a primary residence that is a shelter or similar facility, or who have no primary residence and utilize public areas for sleep, shelter, and daily living activities.

Indian Enrollee – An individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)).

Indian Health Care Provider – an Indian Health Care Provider or an Urban Indian Organization as defined in the American Recovery and Reinvestment Act of 2009.

Indirect Costs – costs charged to the Contractor by its parent to support administration of the Contract, including management, financial or other corporate functions provided to support operation of the program, and exclusive of Direct Costs. Indirect Costs do not include federal and state taxes except sales tax and taxes attributable to personnel.

Individual Care Plan (ICP) – the plan of care developed by a Clinical Care Manager in conjunction with an individual's Care Team, when appropriate and possible. The ICP includes: (1) the individual's detailed and comprehensive needs assessment; (2) identified short-term and long-term treatment goals; (3) a service plan to meet those goals; and (4) the creation of a defined course of action to enhance the individual's functioning and quality of life.

Internal Appeal – a request by a Covered Individual or Appeal Representative made to the Contractor for review of an Adverse Action.

Level of Care – a differentiation of services depending on the setting in which care is delivered and the intensity of the services.

Marketing – as defined in 42 CFR 438.104, any communication, or in the case of "cold-call" Marketing, any unsolicited personal contact, from the Contractor, its employees, Providers, agents or Subcontractors to a Covered Individual who is not enrolled in the PCC Plan or its Behavioral Health Program that reasonably can be interpreted as intended to influence the Covered Individual to enroll in the PCC Plan or its BHP, or either to not enroll in, or to disenroll from, a MassHealth Managed Care Organization or the PCC Plan's BHP. This includes the production and dissemination by or on behalf of the Contractor of any Marketing Materials. Marketing shall not include any personal contact between a Provider and any Covered Individual who is a prospective, current or former patient of that Provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular Covered Individual.

Marketing Materials – as defined in 42 CFR 438.104, materials that are produced in any medium, by or on behalf of the Contractor, and that can reasonably be interpreted as intended for Marketing to Covered Individuals. This includes the production and dissemination by or on behalf of the Contractor of any promotional material or activities by any medium including, but not limited to, oral presentations and statements, community events, print media, audio visual tapes, radio, television, billboards, Yellow Pages, and advertisements that explicitly or implicitly refer to MassHealth Managed Care or Title XIX of the Social Security Act, and are targeted in any way toward Covered Individuals.

Massachusetts Behavioral Health Access System – a web-based searchable database maintained by the Contractor that contains up-to-date information on the number of available beds or available service capacity for certain MassHealth Behavioral Health services, including psychiatric hospitals, Community-Based Acute Treatment Providers, and providers of Intensive Home and Community-Based Services.

MassHealth – the Medicaid program of the Commonwealth of Massachusetts, administered by EOHHS pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto.

MassHealth Basic – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.005.

MassHealth CommonHealth – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.004.

MassHealth Covered Services – medical and behavioral health services or related care provided to Covered Individuals, in accordance with the lists of covered services associated with the MassHealth Coverage Type specified in 130 CMR 505.001 through 505.009.

MassHealth Essential – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.007.

MassHealth Family Assistance – the MassHealth Coverage Type that includes those individuals determined by EOHHS to meet the requirements of 130 CMR 505.006.

MassHealth Provider – a participating individual, facility, agency, institution, organization, or other entity that has appropriate credentials and licensure and has entered into an agreement with EOHHS for the delivery of MassHealth Covered Services to MassHealth Members.

MassHealth Managed Care – the provision of Primary Care, Behavioral Health, and other medical services through a contracted Managed Care Organization or the PCC Plan, in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000 et seq.

MassHealth Member (Member) – any individual determined by EOHHS to meet the requirements of 130 CMR 505.002 or 130 CMR 505.005.

MassHealth Standard – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.002.

Material Subcontractor – any entity from which the Contractor procures, reprocures, or proposes to subcontract with, for the provision of all or part of its Administrative Services for any program area or function that relates to the delivery, management or payment of Covered Services, including but not limited to claims processing, the Care Management Program and other care management activities, PCC Plan Management Support Services, and Utilization Management.

MCPAP for Moms – a statewide program in the Commonwealth to assist medical professionals in supporting a mother's emotional and mental health during pregnancy and the year following birth or adoption. Service includes phone consultations with a MCPAP for Moms psychiatrist to discuss treatment options, personalized recommendations by a psychiatrist, community-based mental health resources and assistance in identifying and/or scheduling community-based mental health services that may include therapy, a psychiatrist, or a support group.

MCPAP Hubs – multiple teams of contracted and credentialed MCPAP Providers with each team responsible for specific geographic centers across the state. Each team shall include MCPAP Providers experienced in providing pediatric mental health and substance use disorder consultation.

Medicaid – see MassHealth.

Medicaid Management Information System (MMIS) – the MassHealth management information system of software, hardware, and manual procedures used to process Medicaid claims and to retrieve and produce eligibility information, service utilization and management information.

Medical Home Load – the portion of the CPCP Rate that provides compensation for transformation costs associated with non-billable services, as described in Section 4.1.A.2.a of **Appendix J-1**.

Medically Necessary (or Medical Necessity) – a service is "Medically Necessary" if:

> (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
> (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007. See, 130 CMR 450.204.

Medication Reconciliation – the process of avoiding inadvertent inconsistencies in medication prescribing that may occur in transition of a patient from one care setting to another (e.g., at hospital admission or discharge, or in transfer from a hospital intensive care unit to a general ward) by reviewing the patient's complete medication regimen at the time of admission, transfer and discharge and comparing it with the regimen being considered for the new care setting.

Member – a person determined by EOHHS to be eligible for MassHealth.

Member Identification Number (MID) – the 10-digit identification number assigned to each MassHealth Member.

Money Follows the Person (MFP) Demonstration – A MassHealth demonstration program authorized through March 31, 2016, pursuant to a federal grant received by OHHS that seeks to assist eligible Members residing in long-term care facility settings to transition to community-based settings where they can receive home and community-based services. See definition of "Money Follows the Person Waivers," below.

Money Follows the Person (MFP) Waivers – Massachusetts waivers for persons participating in the MFP Demonstration and approved by CMS under Sections 1915(c) and 1915(b) of the Social Security Act. Massachusetts operates three separate MFP Waivers. The two 1915(c) Home and Community-Based Services (HCBS) waivers are the Money Follows the Person Residential Supports (MFP-RS) waiver and the Money Follows the Person Community Living (MFP-CL) waiver – each with different covered services and eligibility requirements. The third waiver is the 1915(b) Money Follows the Person Behavioral Health Managed Care (MFP-BH)

waiver. The MFP-BH waiver will serve all individuals enrolled in the MFP-RS and MFP-CL waivers who are not otherwise eligible for managed Behavioral Health benefits.

MFP Waiver Participant – a Covered Individual who is eligible for services pursuant to one of the MFP HCBS Waivers.

MFP Waiver Case Manager – an individual designated by EOHHS who is responsible for performing an assessment to determine the MFP Waiver Participant's care needs in the community. Based upon the MFP Waiver Case Manager's assessment, the MFP Waiver Case Manager will engage in a person-centered planning process with the MFP Waiver Participant, and develop an individual service plan. It is the MFP Waiver Case Manager's responsibility to monitor the provision of services pursuant to the MFP Waiver Participant's individual service plan, and also communicate the individual service plan to the appropriate agencies, organizations and providers; and coordinate the provision of services.

Network (or **Provider Network)** – the collective group of Network Providers who have entered into Provider Agreements with the Contractor for the delivery of BH Covered Services.

Other Provider Preventable Condition (OPPC) – a condition that meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 C.F.R. 447.26(b). OPPCs may occur in any health care setting and are divided into two subcategories:

1. National Coverage Determinations (NCDs) – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:
   a. Wrong surgical or other invasive procedure performed on a patient;
   b. Surgical or other invasive procedure performed on the wrong body part;
   c. Surgical or other invasive procedure performed on the wrong patient.

   For each of a. through c., above, the term "surgical or other invasive procedure" is defined in CMS Medicare guidance on NCDs.
2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as "Additional OPPCs."

Outreach Target – the projected number of Enrollees in each Tier the bidder will attempt to contact annually for Engagement in the Care Management Program each Contract Year.

Participant – a Covered Individual eligible for behavioral health services and who is enrolled in the Care Management Program.

Participating Site – a physical location from which a PCPR Provider provides the Primary Care Services required by the Primary Care Payment Reform Initiative. Participating Sites are listed in **Appendix J-3**.

Patient-Centered Medical Home Initiative (PCMHI) Clinical Care Management Services – services provided by a licensed nurse care manager employed by an EOHHS PCMHI participating practice. The services include stratification of the practice patient population, having contact with patients identified as high-risk no less frequently than every 30 days, case review and planning, including completing, analyzing, and updating as necessary medical bio-

psychosocial support and self-management support assessments, and providing intensive medical and medication management.

Pay for Performance (P4P) – Performance Incentive Arrangement payments the Contractor may earn as described in Contract **Sections 8** and **10**.

Payment Month – the month in which an Estimated Capitation Payment is issued to the Contractor.

Peer Support – activities to support recovery and rehabilitation provided to consumers of Behavioral Health services by other individuals with personal experience with Behavioral Health conditions and services.

Per-Member (Enrollee or **Covered Individual) Per-Day (PMPD) –** the average daily amount to be paid per Enrollee or Covered Individual, depending on context.

Per-Member (Enrollee or **Covered Individual) Per-Month (PMPM)** – the average monthly payment per Enrollee or Covered Individual, depending on context.

Performance Incentive Arrangement – a payment mechanism under which the Contractor may earn payments for meeting targets in the Contract, to the extent that such payments are Actuarially Sound. See 42 CFR 438.6(c)4.

Plan Type – an identifier used by MassHealth's MMIS to identify the Rating Category in which a Covered Individual is enrolled in the BHP.

Positive Parenting Program® (Triple P) – an evidence-based family intervention program, developed by Triple P America, designed to prevent and treat behavioral and emotional problems in children and adolescents and create a family environment that encourages children and adolescents to realize their potential. Triple P draws on social learning and cognitive behavioral and developmental theory as well as research on risk factors associated with the development of social and behavioral problems in children to provide a multi-level parenting and family support training system. The goal of Triple P is to equip parents with the skills and confidence they need to be self-sufficient and to be able to manage family issues without ongoing support.

Post-stabilization Care Services – Covered Inpatient and Outpatient Services, related to an Emergency medical condition that are provided after a Covered Individual is stabilized in order to maintain the stabilized condition, or when covered pursuant to 42 CFR 438.114(e) to improve or resolve the Covered Individual's condition.

Potential Enrollee – a MassHealth Member who is subject to mandatory enrollment or who might voluntarily enroll in one of the Commonwealth's managed care entities but is not yet an enrollee of the managed care entity.

Practice Based Care Management (PBCM) – A model of Integrated Care Management that is delivered by Primary Care Providers to improve member experience, improve care coordination and improve integration of physical and behavioral health care.

Practice Guidelines – systematically developed descriptive tools or standardized specifications for care to assist provider and patient decisions about appropriate health care for specific circumstances. Practice Guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

Pre-Arraignment Protocol (PAP) – a protocol that sets forth a legal-clinical assessment process which allows local police departments to obtain psychiatric hospitalizations, where appropriate, for persons who are arrested but not yet arraigned when the court is closed.

Prevalent Languages – those languages spoken by a significant percentage of Members in the Commonwealth, as determined by EOHHS. Currently, EOHHS has determined that Spanish is a Prevalent Language.

Primary Care – all health care services and laboratory services customarily furnished by or through a family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or nurse practitioner, to the extent the furnishing of those services is legally authorized by the Commonwealth, as further described in 130 CMR 450.101.

Primary Care Activity Level (PCAL) – a factor determined by EOHHS for use in calculating the CPCP, to reflect the age, sex, diagnoses or other characteristics of PCPR Providers' PCC Panel Enrollees.

Primary Care Clinician (PCC) – an EOHHS-contracted Primary Care Practitioner participating in the Managed Care program pursuant to 130 CMR 450.118. PCCs provide comprehensive Primary Care and certain other medical services to PCC Plan Enrollees and function as the referral source for most other MassHealth services.

PCC Hotline – the toll-free telephone line maintained by the Contractor to answer or refer PCC or other PCC Plan provider inquiries. Such inquiries may include, but are not limited to, questions about: the Contractor's responsibilities related to the PCC Plan, including reporting, quality management, operations, PCCs participating in PCMHI, the PCC Provider Contract (see **Appendix C-2**), and other topics as directed by EOHHS.

PCC Member-Level Report – a component of the PCC Plan Management Support Services. The reports shall contain clinical data about specific Enrollees to help PCCs and their service locations monitor and manage Enrollees' care in accordance with recommended guidelines.

PCC Panel Enrollee – an Enrollee who is assigned to the PCPR Provider. Panel Enrollees do not include MassHealth Members enrolled with an OneCare Plans or who have third-party insurance.

PCC Performance Dashboard – a component of the PCC Plan Management Support Services. These PCC-specific and/or PCC service location-specific reports shall contain agreed upon indicators to help PCCs and their service locations monitor their performance and to identify opportunities for quality improvement.

PCC Plan – a MassHealth Managed Care option, which includes EOHHS's network of PCCs, specialty care providers and the BHP.

PCC Plan Management Support Services (MSS) – services designed to support MassHealth in managing the PCC Plan in a cohesive fashion with a focus on quality management and operational support.

PCC Plan Management Support Materials – educational materials distributed by the Contractor to PCCs (and other providers as appropriate) to promote improvement in the delivery of health care services and in Enrollee health outcomes.

PCC Plan Regional Network Managers – Contractor staff dedicated solely to the Contract, with appropriate network management, QM, provider relations, and relevant clinical background and experience.
PCC Provider Contract – a PCC's written agreement with EOHHS to be a PCC in the PCC Plan.

PCC Service Location – the site at which an Enrollee is enrolled once an Enrollee chooses or is assigned to the PCC Plan. A PCC Service Location is denoted by a Provider Identification and Service Location (PID/SL) number which is system-generated by the EOHHS MMIS. A PCC may have one Service Location or multiple Service Locations.

Primary Care Payment Reform Initiative (PCPRI or **PCPR Initiative)** – an EOHHS care delivery program to begin in calendar year 2014 to improve access to care, member experience, quality of care, and overall efficiency in service delivery by emphasizing Patient-Centered Medical Homes, the integration of Primary Care services with Behavioral Health services and MassHealth's use of an alternative payment mechanism for participating providers.

PCPR Provider – a Primary Care Clinician that has signed the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract to participate in PCPR with MassHealth, a model of which is included as **Appendix J-1**. A list of PCPR Providers providing Tier 2 and Tier 3 PCPR Covered Services is included as **Appendix J-3**.

Primary Care Practitioner (PCP) – a health care professional who provides Primary Care services.

Privacy Rule – the standards for privacy of individually identifiable health information required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended).

Protected Health Information (PHI) – any information in any form or medium: i) relating to the past, present or future, physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual, and ii) identifying the Individual or with respect to which there is a reasonable basis to believe can be used to identify the Individual. PHI shall have the same meaning as used in the Privacy Rule. PHI constitutes Personal Data as defined in M.G.L. c. 66A, § 1.

Providers – an individual, group, facility, agency, institution, organization, or business that furnishes or has furnished medical services to Covered Individuals.

Provider Agreement – a binding agreement between the Contractor and a BH Network Provider that includes, among other things, all of the provisions set forth in **Section 3.1.C**.

Provider Preventable Conditions (PPC) – as identified by EOHHS through bulletins or other written statements policy, which may be amended from time to time, a condition that meets the definition of a "Health Care Acquired Condition" or an "Other Provider Preventable Condition" as defined by CMS in federal regulations at 42 C.F.R. 447.26(b).

Quality Management (QM) – the process of reviewing, measuring and continually improving the outcomes of care delivered.

Rating Category (RC) – a specific group of Covered Individuals for which a discrete BH Covered Services Capitation Rate applies, as described in **Section 10.2**.

Reportable Adverse Incident – an occurrence that represents actual or potential serious harm to the well-being of a Covered Individual, or to others by the actions of a Covered Individual, who is receiving services managed by the Contractor or has recently been discharged from services managed by the Contractor.

SBIRT (Screening, Brief Intervention and Referral to Treatment) – an evidence based approach addressing adolescent substance use/abuse in health care settings.

Serious Emotional Disturbance (SED) – a Behavioral Health condition that meets the definition set forth in the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1401(3)(A)(i) and its implementing regulations or the definition set forth in regulations governing the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services, 58 Fed. Reg. 29422-02 (May 10, 1993), as currently drafted and subsequently amended.

Serious Mental Illness – a substantial disorder of thought, mood, perception, orientation or memory in an adult, which: significantly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; has lasted or is expected to last at least one year; has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities; meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), as currently drafted and subsequently amended; and is not based on symptoms primarily caused by substance use, mental retardation or organic disorders.

Serious and Persistent Mental Illness (SPMI) – a mental illness that includes a substantial disorder of thought, mood, perception, which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and is the primary cause of a functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders; or (b) cognitive disorders,

including delirium, dementia or amnesia; or (c) mental disorders due to a general medical condition not elsewhere classified; or (d) substance-related disorders.

Serious Reportable Event (SRE) – an event that is specified as such by EOHHS.

Service Compensation Rate – a dollar amount to be paid monthly by EOHHS to the Contractor for the delivery of ESP Services to Uninsured Individuals and persons covered by Medicare only, Forensic Evaluation services and MCPAP services as set forth in this Contract.

Service End Date – the date, as determined by EOHHS, on which the Contractor's responsibility for the administration, delivery and coordination of the functions and responsibilities described in this Contract shall terminate.

Service Start Date – the date, as determined by EOHHS, on which the Contractor assumes responsibility for the administration, delivery and coordination of the functions and responsibilities described in this Contract.

Southeast Area – is comprised of Bristol, Plymouth, Barnstable, Dukes, Nantucket and a portion of Norfolk counties and includes the following municipalities:

Abington	Dennis	Harwich	Onset	Swansea
Acushnet	Dighton	Holbrook	Orleans	Taunton
Aquinnah	Duxbury	Hyannis	Osterville	Tisbury
Attleboro	East Bridgewater	Kingston	Pembroke	Truro
Avon	Easton	Lakeville	Plymouth	Vineyard Haven
Barnstable	Eastham	Mansfield	Plympton	Wareham
Berkley	Edgartown	Marion	Pocasset	Wellfleet
Bourne	Fairhaven	Marshfield	Provincetown	West Bridgewater
Brewster	Fall River	Mashpee	Raynham	Westport
Bridgewater	Falmouth	Mattapoisett	Rehoboth	West Tisbury
Brockton	Freetown	Middleborough	Rochester	Whitman
Carver	Gay Head	Nantucket	Rockland	Woods Hole
Chatham	Gosnold	New Bedford	Sandwich	Yarmouth
Chilmark	Halifax	North Attleboro	Seekonk	
Cotuit	Hanover	Norton	Somerset	
Dartmouth	Hanson	Oak Bluffs	Stoughton	

Third-Party Liability (TPL) – other insurance resources, such as Medicare and commercial insurance, available for services delivered to MassHealth Members.

Tier – a division or category within the Care Management Program's system of stratification.

Tier 1 Billable Services Rate – the portion of the CPCP for payment of Tier 1 medical services.

Tier 1 CPCP Covered Services – medical expenses included within the CPCP Covered Services as detailed in **Appendix J-5**.

Tier 2 CPCP Covered Services – a minimum set of Behavioral Health Covered Services included within the CPCP Covered Services as detailed in **Appendix J-5.**

Tier 3 CPCP Covered Services – a maximum set of Behavioral Health Covered Services included within the CPCP Covered Services as detailed in **Appendix J-5.**

Uninsured Individuals – those individuals who are not MassHealth or CommCare eligible for any reason, and do not have commercial insurance.

Urgent Care Services – services that are not Emergency Services or routine services.

Utilization Management (UM) – the process of evaluating the clinical necessity, appropriateness, and efficiency of care and services. This may include service authorizations and prospective, concurrent, and retrospective review of services and care delivered by Providers.

Virtual Gateway – an internet portal designed and maintained by EOHHS to provide the general public, medical providers, community-based organizations, MassHealth Managed Care contractors, and EOHHS staff with online access to health and human services.

Voluntary Pooled PCPR Providers – PCPR Providers that aggregate the number of PCC Panel Enrollees in each PCPR Provider's panel by choice, in accordance with the PCPR Provider's PCC Plan Contract with EOHHS.

Wellness Programs – programs that promote an active process to help individuals become aware of and learn to make healthy choices that lead toward a longer and more successful existence.

Acronyms

The following acronyms are commonly used in the health care industry and/or frequently found throughout this Contract and its Appendices:

ABA – Applied Behavioral Analysis
ACA (or PPACA) – the Patient Protection and Affordable Care Act of 2010
ALP **–** Alternative Lock-up Programs
AND – administratively necessary day
BBA – Balanced Budget Act of 1997
BH – behavioral health
BHP – behavioral health program
BOH – Board of Hearings
BORIM – Board of Registration in Medicine
CANS – child and adolescent needs and strengths
CBHI – children's behavioral health initiative
CFR – Code of Federal Regulations
CMP – care management program
CMR –Code of Massachusetts Regulations
CMS – the federal Centers for Medicare and Medicaid Services
CPCP **–** Comprehensive Primary Care Payment
CSA – community service agency

CSMP – controlled substance management program
DCF – the Massachusetts Department of Children and Families
DDS – the Massachusetts Department of Developmental Services
DHCFP – the Massachusetts Division of Health Care Finance and Policy
DMH – the Massachusetts Department of Mental Health
DPH – the Massachusetts Department of Public Health
DPH/BSAS – Bureau of Substance Abuse Services of the Mass. Department of Public Health
DRM – Document Review Measure
DSRA – direct service reserve account
DUR – drug utilization review
DYS – the Massachusetts Department of Youth Services
ECC – Enhanced Care Coordination
ED – emergency department
EESPA **–** Expected External Service Provision Adjustment
EOHHS – the Massachusetts Executive Office of Health and Human Services
EPSDT – Early and Periodic Screening, Diagnosis and Treatment
ESP – emergency services program
EQR –external quality review
EVS – Eligibility Verification System
FFP – federal financial participation
FFS – fee-for-service
FTE – full-time equivalent
FY – fiscal year
HCBS – Home and Community-Based Services
HEDIS – Healthcare Effectiveness Data and Information Set
HIPAA – Health Insurance Portability and Accountability Act of 1996
HNA – Health Needs Assessment
IBNR – incurred but not reported
ICC – intensive care coordination
ICM – intensive clinical management
ICMP – Integrated Care Management Program
LEIE – Office of the Inspector General List of Excluded Individuals Entities
MBR – MassHealth benefit request (application) form
MCO – managed care organization
MCPAP – Massachusetts child psychiatry access project
MFD – Medicaid Fraud Division
MFP – Money Follows the Person
MGL – Massachusetts General Laws
MID – member identification number
MIS – management information system
MLR – PCC Member-Level Report
MMIS – Medicaid Management Information System
MSS – PCC Plan management support services
NCQA – National Committee for Quality Assurance
NPI – national provider identifier
OCA – Office of Clinical Affairs
P4P – pay for performance
PAP – pre-arraignment protocol

PBCM – Practice Based Care Management
PBHMI – Pediatric Behavioral Health Medication Initiative
PCAL – Primary Care Activity Level
PCC – primary care clinician
PCMHI – patient-centered medical home initiative
PCP – primary care practitioner
PCPR – primary care payment reform
PD – PCC Performance Dashboard
PID/SL – provider identification and service location
PIHP – Prepaid Inpatient Health Plan
PMPD – per member (covered individual or enrollee) per day
PMPM – per member (covered individual or enrollee) per month
POPS – Pharmacy Online Processing System
PPHSD – Preventive Pediatric Health-Care Screening and Diagnosis
PPPM – per participant (in the Care Management Program) per month
PPSS – Provider Partner Support Services
S2BI – Screening to Brief Intervention
SBIRT – Screening, Brief Intervention, and Referral to Treatment
SED – serious emotional disturbance
SRE – serious reportable event
TPL – third-party liability
QI – quality improvement
QM – quality management
UM – utilization management
VG – Virtual Gateway

GENERAL ADMINISTRATIVE REQUIREMENTS

Transition to the Contractor

Transfer of Responsibilities

The Contractor shall:

Ensure that there is no interruption of Behavioral Health Covered Services to Covered Individuals and Uninsured Individuals.

Ensure that the existing toll-free telephone number (800-495-0086), is operative at the Contractor's office as of midnight (Eastern Time) on the Service Start Date and remains operative for the duration of the Contract, unless otherwise directed or agreed to by EOHHS. The number shall continue to offer all appropriate menu options to provide Contract-related information to PCCs, Network Providers, and Covered Individuals, including the PCC Plan Hotline. (See **Section 9.7** for specific telephone system requirements.)

At least 30 days prior to the Service Start Date, obtain all records, reports and data related to the previous PCC Plan's Behavioral Health Program contract ("previous BHP contract") in the manner and method specified by EOHHS, including but not limited to information pertaining to:

Utilization:

Preauthorization and continuing stay (concurrent review) files for all Levels of Care; and

Management reports identifying the next scheduled concurrent review and discharge review dates;

Care Management, including all current authorizations, individual care plans, clinical case notes and utilization history for individuals receiving Care Coordination, Targeted Outreach, and Intensive Clinical Management, including as of 14 calendar days before the end of the previous BHP contract;

Prior authorizations for all Levels of Care:

Inpatient Services admissions for the last 30 calendar days of the previous BHP contract;

Outpatient Services authorizations ending on or before 30 calendar days after the last calendar day of the previous BHP contract;

Diversionary Services for the last 30 calendar days of the previous BHP contract;

Clinical notes and individual case information;

Provider credentialing;

Provider fraud investigations;

Complaints from Covered Individuals;

Grievances from providers and Covered Individuals;

Adverse Incident investigations;

Quality Management plan;

Quality Improvement Project records;

Information on the previous BHP provider network, including:

A provider list containing the provider's name, type of provider, address, administrative contact person and clinical contact person;

The previous BHP contract's network management plan with provider files and improvement goals; and

All Appeals and Claim reviews filed under the previous BHP contract and not yet investigated and resolved.

Implementation

The Contractor shall:

Develop and submit to EOHHS for approval, no later than 14 days after notification that EOHHS has selected it for Contract negotiations, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first Contract Year, including the readiness activities for the Service Start Date.

Provide EOHHS with updates to the initial work plan and timeline, identifying adjustments that have been made to either, and describing the Contractor's current stage of readiness to perform all Contract obligations. Until the Service Start Date, the Contractor shall provide an update every two weeks to the work plan and timeline, and thereafter as often as EOHHS determines is necessary.

Unless otherwise agreed to by EOHHS, submit to EOHHS all deliverables, including but not limited to those identified in **Appendix B**, that must be in place by the times specified in this Contract; or, if not specified, in sufficient time to permit any EOHHS-identified modifications to be made by the Service Start Date.

Ensure that all workplace requirements EOHHS deems necessary, including but not limited to office space, post office boxes, telephones and equipment, are in place and operative as of the Service Start Date.

Establish its Provider Network and maintain existing Provider Agreements with such Providers, all in accordance with the provisions set forth in **Section 3.1.C**.

Perform all functions described in the Contract as of the Service Start Date, unless otherwise specified or agreed to by EOHHS.

Clinical Transition Plan

The Contractor shall:

Prepare to assume responsibility as of the Service Start Date for the clinical management, service authorization, and Claims payment functions for Covered Individuals who are receiving Inpatient Services or have open Outpatient or Diversionary Service authorizations or registrations on the Service Start Date.

No later than one month prior to the Service Start Date, prepare to accept transfer of all authorizations that are valid for dates of service after the Service Start Date; and each business day beginning 30 days prior to the Service Start Date, transfer from the previous BHP contract information on all services that were registered the previous day and that are valid for dates of service after the Service Start Date.

Prior to the Service Start Date, ensure that sufficient staff have been recruited, hired and trained to perform all requirements of the Contract on the Service Start Date, unless otherwise agreed to by the parties.

Prior to the Service Start Date, provide written instructions to those network and non-network providers from the previous BHP contract regarding any changes from the previous BHP contract to the Contractor's service authorization requirements and procedures for using the service authorization system, and schedule training sessions with Network Providers to review policies and procedures for any such changes, as necessary.

For Covered Individuals who have registered or prior-authorized BH Covered Services in place by the day before the Service Start Date, honor all such authorizations through their end dates.

For any Covered Services authorized under the previous BHP contract, adjudicate and pay claims from BH Network Providers under the previous BHP contract for services provided on or after the Service Start Date.

Contract Requirements for EOHHS Readiness Review

Prior to the Service Start Date, and no later than 60 days prior to enrollment of Covered Individuals into the Contractor's Plan, and at other times during

the Contract period at the discretion of EOHHS, EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional Readiness Review in the event that additional populations become managed care eligible. The EOHHS Readiness Review may include on-site review. The Contractor shall demonstrate to EOHHS satisfaction that all elements required for readiness are in place, including but not limited to:

All deliverables that EOHHS has specified must be in place prior to the Service Start Date, as set forth in **Appendix B**;

Network Provider composition and access;

Staffing, including Key Personnel and functions directly impacting on Enrollees;

Capabilities of Material Subcontractors;

Care Management capabilities;

Content of Provider Agreements, including any Provider performance incentives;

Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities);

Comprehensiveness of quality management/quality improvement and Utilization Management strategies;

Internal Grievance and Appeal policies;

Fraud and Abuse detection and protocols, Third-Party Liability Benefit Coordination and Recovery and program integrity;

Financial solvency;

Information systems, including claims payment system performance, interfacing and reporting capabilities, validity testing of Encounter Data, IT testing and security assurances.

Covered Individuals may not be enrolled with the Contractor until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Service Start Date, and EOHHS does not agree to postpone the Contract Service Start Date or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

Contractor's Organization

Organizational Philosophy

The Contractor shall maintain and make available to EOHHS upon request an organizational statement that describes the Contractor's philosophy, operating history, mission, organizational structure, ownership structure, and plans for future growth and development of its organization.

Location

The Contractor shall:

Unless the parties agree otherwise, maintain for the term of the Contract a principal place(s) of business in Massachusetts that is acceptable to EOHHS.

Maintain for the term of the Contract a backup site, separate from its principal place of business, that fulfills the Contract requirements for disaster recovery described in **Section 13.36**.

Notify EOHHS and obtain EOHHS's approval of any proposed change to the location of the Contractor's principal place(s) of business, at least 30 calendar days before making the proposed change.

Upon EOHHS's request for good cause, and upon adequate notice, work with EOHHS to identify an alternative location for the Contractor's principal place(s) of business, and, as agreed to by the parties, move its operation to said location.

Contract Officer

The Contractor shall:

Designate a qualified individual dedicated solely to the Contract to serve as Contract Officer who shall act as the liaison between the Contractor and EOHHS, authorized and empowered to represent the Contractor in all matters pertaining to the Contract. Such designation may be changed during the period of the Contract only by written notice to and approval by EOHHS.

Ensure that the Contract Officer holds an executive-level key personnel position in the Contractor's organization, except that the Contractor may propose for EOHHS's prior review and approval an alternate structure for the Contract Officer position.

The Contract Officer's responsibilities shall include:

Ensuring the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

Overseeing the Contractor's implementation of all EOHHS-approved plans, policies and timelines;

Overseeing all Contract-related activities by the Contractor, each Material Subcontractor and all other subcontractors, including coordinating with the Contractor's key personnel as described in **Section 2.2.F.1**;

Receiving and responding to all inquiries and requests made by EOHHS related to the Contract, in the time frames and formats specified by EOHHS;

Meeting with EOHHS's Contract Manager(s) on a routine basis as agreed upon by the parties, to discuss issues of mutual interest or concern;

Coordinating requests and activities among the Contractor, all subcontractors, and MassHealth/DMH staff;

Working to promptly resolve any Contract-related issues identified by the Contractor or EOHHS; and

Tracking the compliance of all Contract requirements and deliverables and maintaining records of all compliance activities and compliance dates using an electronic software tool or other similar mechanism such as a spreadsheet. Tracking of Contract compliance shall be in a format that can be shared with EOHHS upon request or an agreed-upon reporting schedule. Such tool or tracking mechanism shall be maintained in the Contract as **Appendix B-2**. All deliverables, reports, contracts, subcontracts, agreements and any other documents subject to EOHHS approval shall be provided to EOHHS in accordance with Contract requirements.

Communications

Access to Administrative Personnel

The Contractor shall:

Maintain a local telephone line for administrative personnel, for communicating with EOHHS in an effective and timely manner and ensuring that EOHHS is informed of all circumstances that materially affect service delivery or the management and administration of the Contract;

Ensure that its system for communicating with EOHHS includes direct telephone access, voice mail and electronic mail capacity for, at a minimum, all of the Contract's key personnel and senior-level management staff;

Require all staff to utilize a voice mail messaging system to inform callers of all planned and unplanned absences from work, to check their messages periodically when working offsite, and to identify a designee who will handle their calls in their absence;

Provide to EOHHS, when available and whenever changes occur, a list of telephone numbers, titles and e-mail addresses of, at a minimum, the Contractor's key personnel and senior-level management staff; and

Ensure that the Contractor utilizes the EOHHS secure e-mail system for all communications involving Protected Health Information (PHI).

Quality Oversight of Written Materials

The Contractor shall submit all materials intended for general distribution to Covered Individuals, Uninsured Individuals, Providers and Primary Care Clinicians (PCCs) up to the standards of professional business standards, and in compliance with 42 CFR 438.10, before submitting them to EOHHS for review and approval and prior to publication.

Organizational Structure and Staffing

The Contractor shall:

Submit to EOHHS for approval, at least 60 calendar days prior to the Service Start Date an organizational chart depicting the functions and reporting relationships for the performance of the Contract;

Notify EOHHS in writing at least 30 calendar days prior to making any significant changes to its internal organizational structure;

Recruit and maintain an appropriately qualified and diverse workforce, sufficient in number for the efficient execution of all Contract responsibilities;

Recruit and maintain an adequate number of appropriately qualified staff in order to perform Network Management activities efficiently in the communities across the Commonwealth, so that Covered Individuals and BH Network Providers, PCCs and Providers have timely access to Contractor staff in all regions of Massachusetts;

Make best efforts to maintain a staff that reflects the cultural, linguistic and demographic characteristics of Covered Individuals, including a sufficient number of bilingual staff capable of communicating in English and Spanish, and other languages as appropriate; and

Ensure that it properly allocates and tracks the time expended by Key Personnel and, as appropriate, other personnel among the administration of the PCC Plan's BHP, PCC Plan Management Support Services and DMH Specialty Programs administration.

Key Personnel and Senior Management Staff

The Contractor shall identify key personnel and senior-level management staff with clearly delineated authority over all functions of the Contract.

Key Personnel

The Contractor shall:

Employ the following or similarly titled or functional full-time personnel designated as key personnel under the Contract, employed in the key personnel position only upon review by EOHHS:

Chief Executive Officer;

Chief Financial Officer;

Chief Operating Officer;

Chief Information Officer;

Chief Medical Officer (see **Section 4.1.B.4**);

Associate Medical Directors (see **Section 4.1.B.4**);

Behavioral Health Plan Network Management Director;

PCC Plan Management Support Services Director (see **Section 5.2.A.1**)

Contract Officer (see **Section 2.2.C**).

EOHHS further reserves the right to be informed of a decision by the Contractor to dismiss any of the key personnel.

Develop and maintain detailed job descriptions for each key personnel position that will have ongoing responsibility for Contract functions.

Designate the Chief Executive Officer as the person responsible for the Contract in its entirety and who ensures that there is coordination and integration, as appropriate, of functions across the activities related to BH services, administrative services related to the PCC Plan, the full range of Care Management activities, and Specialty Services managed by the Contractor.

Submit the name, title and curriculum vitae of each person holding a key personnel position to EOHHS prior to the Service Start Date and whenever a change occurs.

Non-Performance

The Contractor shall:

Respond promptly to any EOHHS concerns regarding the performance of any key personnel under the Contract.

Take any action related to any personnel that the Contractor reasonably determines is necessary to ensure full compliance with the terms of the Contract, and notify EOHHS of such actions.

Contract Representative(s) and Liaison(s)

Prior to the Service Start Date and whenever a change occurs, the Contractor shall submit to EOHHS the name(s) and titles(s) of a senior-level or executive individual(s) who will have responsibility for ongoing administrative, clinical, fiscal and programmatic interaction with EOHHS, DMH central and area offices, and DCF central and regional offices.

Staff Training

The Contractor shall:

Develop, and submit to EOHHS for review and approval prior to the Service Start Date, a training program and curriculum that provides its staff with the knowledge and skills they require to effectively, correctly and competently perform their functions under the Contract.

Thereafter maintain the training program and update it at EOHHS's request. In addition, EOHHS reserves the right to require additional training programs at its discretion.

Evaluate the effectiveness of the training program on an annual basis or as directed by EOHHS

Material Subcontractors

The Contractor shall:

By the Service Start Date and subsequently at least 60 days prior to the date the Contractor expects to execute a contract for a Material Contractor, submit to EOHHS for review and approval the identity of any Material Subcontractors the Contractor has hired to perform any of the requirements of the Contract and the names of their principals, along with the Material Subcontractor Checklist and completed federally required disclosure forms (see **Appendix B-4**), if required in accordance with **Section 13.2.** The Contractor shall request such approval in writing and submit with that request a completed Material Subcontractor Checklist using the template provided by EOHHS and attached hereto as **Appendix B-3**, as may be modified by EOHHS from time to time. The Contractor must describe the process for selecting the Material Subcontractor, including the selection criteria used. The Contractor shall provide EOHHS

with any additional information requested by EOHHS in addition to the information required in the Material Subcontract Checklist;

Maintain all agreements and subcontracts relating to this Contract in writing. All such agreements and subcontracts shall fulfill applicable requirements of 42 CFR Part 438, and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity, specifically including but not limited to the provisions related to privacy and confidentiality (**Section 14**) and record retention (**Section 13.21**);

Remain fully responsible for meeting all of the requirements of the Contract regardless of whether the Contractor subcontracts for the performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibility under the Contract;

Actively monitor the quality of care provided to Covered Individuals under any Provider Agreements and any other subcontracts;

Prior to contracting with a Material Subcontractor, the Contractor shall evaluate the prospective Material Subcontractor's ability to perform the activities to be subcontracted;

Have a written agreement with the Material Subcontractor that specifies the activities and report responsibilities delegated to the Material Subcontractor and provides for revoking delegation or imposing other sanctions if the Material Subcontractor's performance is inadequate;

Monitor the Material Subcontractor's performance on an ongoing basis and subject it to formal review annually. If any deficiencies or areas for improvement are identified, the Contractor and the Material Subcontractor shall take corrective action;

Notify EOHHS in writing immediately upon notifying any Material Subcontractor of the Contractor's intention to terminate any such subcontract;

Submit annually to EOHHS a list of all Material Subcontractors. Such annual report shall include notification if any of its Material Subcontractors are certified Minority Business Enterprises. The Contractor shall submit an updated list at least 30 days in advance of any changes to the list or as otherwise directed by EOHHS.

Organizational Certifications, Requirements and Prohibitions

EOHHS shall have the sole discretion and authority to determine whether the Contractor has satisfied the requirements of subsections **1** and **2** below.

Certification of Readiness to Perform

The Contractor hereby represents and warrants that as of the Service Start Date it has performed all of the requirements set forth in **Section 2.1** of this Contract; and has submitted to EOHHS for review and approval all deliverables as agreed to by the parties, including but not limited to those identified in **Appendix B-1**, that are required to be submitted by the Service Start Date; and that on the Service Start Date and at all times

during the term of the Contract it is ready, willing and able to perform all of the requirements of the Contract without modification.

Business Requirements and Representations and Warranties

The following definitions apply to this **Section 2.2.I**:

Related Entity – any and all of the Contractor's partners, Parents, subsidiaries, and any other entity directly or indirectly related to the Contractor, as well as any and all of the Contractor's Material Subcontractors, and such Material Subcontractors' partners, Parents, subsidiaries, and any other entity directly or indirectly related to any such Material Subcontractor.

Restricted Activity – an activity that involves directly or indirectly owning or controlling any interest in, or operating, managing, or otherwise engaging in any business activity with any entity in Massachusetts, New Hampshire, Rhode Island, Vermont, Maine, Connecticut or New York that delivers or manages the delivery of BH Covered Services listed in **Appendix A-1** of this Contract to Covered Individuals or Uninsured Individuals.

The Contractor shall comply with each of the following requirements and hereby represents and warrants that it does so comply and will continue to so comply at all times during the term of this Contract:

The Contractor and each Material Subcontractor, if any, is organized primarily for the purpose of administering and coordinating the delivery of health care services.

Neither the Contractor nor any Related Entity engages in a Restricted Activity.

Notwithstanding the provisions of subsection **2)**, the Contractor or a Related Entity may engage in a Restricted Activity, as specified by EOHHS, if the Contractor has requested and received EOHHS's prior written approval to do so, in accordance with subsection **3**, below.

Request for Contractor or Related Entity to Engage in Restricted Activity and Plan to Assure against Conflict

The Contractor shall request in writing EOHHS's approval of any proposal under which the Contractor or any Related Entity would engage in a Restricted Activity. EOHHS may in its sole discretion approve, modify or deny, in whole or in part, the Contractor's request or any proposed plan. Such request shall:

Specifically describe the Restricted Activity in which the Contractor or Related Entity proposes to engage;

Specifically describe the reasons for the request;

Include a statement certifying that the Contractor's proposed plan ensures that the Contractor is in compliance with all applicable state and federal laws and regulations; and

Contain a complete description of the Contractor's specific plan to ensure that the Contractor will not favor any Network Provider with which the Contractor or a Related Entity proposes to engage in a Restricted Activity. To favor such a provider includes without limitation:

preferentially, disproportionately or inappropriately utilizing that Network Provider's services;

offering that Network Provider preferential rates or any other preferential form of remuneration;

applying lower performance, quality of care, or any other standards to that Network Provider; or

otherwise treating that Network Provider in any preferential or disparately advantageous way.

General Prohibition against Conflicts with Contractual Obligations

The Contractor and its Material Subcontractor(s) shall have no interest, including without limitation financial, legal or other business interest, nor shall the Contractor or its Material Subcontractor(s) engage in any activity at any time during the term of this Contract that, in EOHHS's sole determination, conflicts with any of the Contractor's obligations hereunder, specifically including the performance of services required under this Contract. Without limiting the generality of the foregoing, EOHHS requires that:

Neither the Contractor nor any Material Subcontractor have any financial, legal contractual or other business interest in EOHHS's Customer Services vendor or such vendor's subcontractors, if any; and

Neither the Contractor nor any Material Subcontractor nor any Related Entity engage in any Restricted Activity, except in accordance with this **Section 2.2.I**.

Required Termination of Agreements with Certain Providers and Other Entities

If EOHHS in its sole discretion determines that the Contractor has failed to comply with or otherwise satisfy the requirements of subsections **3** and **4**, above, EOHHS may require the Contractor to terminate:

Any such Network Providers from its Network; or

Any agreements or other arrangements with non-Network Providers or other entities in which or with which the Contractor has an interest or engages in an activity that is inconsistent with the terms of this Contract.

EOHHS Approval of Contractor's Corporate Policies

The Contractor shall, upon EOHHS's request, provide for review and approval any internal policies, procedures or practices developed by the Contractor, its Parent(s) or affiliates that may affect the Contractor's performance of its obligations under the Contract, including without limitation:

Policies that could affect the Contractor's ability to provide adequate staff to perform its Contract obligations;

Choice of vendors for administrative services;

The imposition of limits on administrative spending; and

Those related to the Contractor's purchase of supplies, materials, and telephone and information systems necessary to perform its obligations under the Contract.

Requirements Related to the Contractor's Financial Condition and Structure

The Contractor hereby represents and warrants that the Contractor and each of its Material Subcontractors is in sound financial condition and will remain so at all times during the term of this Contract.

As a condition of the Contract, the Contractor shall comply and shall ensure that each Material Subcontractor complies with each of the following requirements, and hereby represents and warrants that it and each Material Subcontractor does so comply and will continue to so comply at all times during the term of this Contract.

If the Contractor or any Material Subcontractor is organized as a partnership or joint venture:

All entities that constitute the partners that the Contractor comprises as of the date of the execution of the Contract shall sign the Contract and shall be jointly and severally liable for all obligations under and relating to the Contract for the duration of the Contract and all additional periods required thereunder, notwithstanding any inconsistent act or agreement by or among any of the partners;

Upon request, the Contractor and each Material Subcontractor shall immediately submit to EOHHS its partnership agreements, any amendments

thereto, and any other documents related to its partnership obligations as they relate to the Contract;

During the term of the Contract, the Contractor and each Material Subcontractor shall submit to EOHHS all proposed changes to their respective partnership agreements for EOHHS's prior review and approval prior to execution, including but not limited to changes related to adding to or otherwise changing the partners that the Contractor and each Material Subcontractor comprised as of the date of Contract execution;

The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent, if any, of each and every business partner in order to guarantee and secure any obligations set forth in this Contract.

If the Contractor or any Material Subcontractor is a publicly traded corporation:

All filings submitted to the Securities and Exchange Commission by the Contractor or Material Subcontractors shall contemporaneously be submitted to EOHHS.

All ownership interests of 5 percent or more in the Contractor or Material Subcontractor shall be disclosed to EOHHS.

The Contractor and each Material Subcontractor shall be in good standing with the Secretary of State's office in the state where it is incorporated.

The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent(s) of the Contractor, if any, in order to guarantee and secure any obligations set forth in this Contract.

If the Contractor or any Material Subcontractor is a closely held corporation:

All ownership interests of 5 percent or more in the Contractor or Material Subcontractor shall be disclosed to EOHHS.

The Contractor and each Material Subcontractor shall be in good standing with the Secretary of State's office in the state where it is incorporated.

The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent(s), if any, of the Contractor in order to guarantee and secure any obligations set forth in this Contract.

At the request of EOHHS, the Contractor shall provide and shall require each Material Subcontractor to provide EOHHS with documentation relating to organizational and financial structure, including but not limited to:

the name(s) and address(es) of any Parent organization(s), all partially or wholly owned subsidiary(ies) and/or any other organization(s) related directly or indirectly to the Contractor; and

the names and occupations of the members of the Contractor's Board of Directors, and of the subsidiary(ies) and/or any other organization(s) related directly or indirectly to the Contractor.

The Contractor hereby represents and warrants that its provision against the risk of insolvency is adequate to ensure that Covered Individuals will not be liable for the Contractor's debts if the Contractor becomes insolvent.

Requirements Related to the Contractor's Compliance with HIPAA

The Contractor represents and warrants that:

It will conform to all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations, including but not limited to those contained in **Section 14**, no later than the compliance date of each of those requirements or regulations;

It shall at all times subsequent to the applicable compliance dates be in compliance with such requirements and regulations; and

It shall work cooperatively with EOHHS on all activities related to compliance with HIPAA requirements, as directed by EOHHS.

Certification of Capacity to Meet Access Standards

The Contractor hereby represents and warrants that at all times during the term of the Contract it has the capacity to service expected enrollment of Covered Individuals in accordance with the access standards specified in **Sections 3.1.G.6** and **3.1.G.7**.

Certification of NCQA Accreditation Status

The Contractor will submit current NCQA status including the schedule for accreditation and/or the schedule for remedies necessary for accreditation.

Compliance with Data Certification, Program Integrity and Prohibited Affiliation Requirements

As a condition of receiving payment under this Contract, the Contractor must comply with all applicable data certification, program integrity and prohibited affiliation requirements at 42 CFR 438.600 et seq., and as described in **Sections 3.7.H, 11.1** and **11.2**.

Delivery of Services and Coordination of Services

Delivery of Services to Covered Individuals

The Contractor shall:

Be responsible for ensuring the delivery of all BH Covered Services as they are described in **Appendix A-1** to all Covered Individuals that are eligible on the date of service.

Arrange, coordinate, authorize and pay for the provision of all Medically Necessary BH Covered Services.

Inform Covered Individuals of the MassHealth-established access standards for and the availability of all Medically Necessary BH Covered Services and how to obtain such services.

Incorporate the provisions of 130 CMR 450.204 into all criteria for BH Covered Services.

Provide all BH Covered Services that are Medically Necessary, including but not limited to those BH Covered Services that:

prevent, diagnose, or treat the Covered Individual's health impairments;

assist the Covered Individual to achieve age-appropriate growth and development; and

allow the Covered Individual to attain, maintain, or regain functional capacity.

Not arbitrarily deny or reduce the amount, duration, or scope of a required BH Covered Service solely because of diagnosis, type of illness, or condition of the Covered Individual. The Contractor may place appropriate limits on a BH Covered Services on the basis of Medical Necessity and utilization management, however such limitation are still to be considered an Adverse Action.

Orient the provision of BH Covered Services to the Covered Individual's strengths and preferences, his/her aspirations for recovery, and

encouragement of overall health and wellness. For Covered Individuals under age 18, actively involve parent(s) or legal guardian(s) in treatment.

Allow each Enrollee to choose his or her health professional to the extent possible and appropriate.

Delivery of Services to the Uninsured

The Contractor shall provide Uninsured Individuals and persons covered by Medicare only with Medically Necessary ESP Services without regard to enrollment in the BHP.

Third-Party Liability Benefit Coordination and Recovery

The Contractor shall:

By the Service Start Date, develop and submit to EOHHS for approval a work plan for Third-Party Liability (TPL) benefit coordination and recovery that:

Ensures that MassHealth is the payer of last resort for the BH Covered Services provided under this Contract;

Ensures recovery of funds inappropriately paid to Network Providers;

Avoids payment for all Claims or services that are subject to third-party payment;

Ensures that the Contractor identifies and determines the legal liability of third parties to pay for services furnished to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only;

Includes tasks and time frames associated with the plan; and

Addresses systems and resources required to perform at a minimum the following activities:

Identification of Covered Individuals and Uninsured Individuals who have other health insurance, and notification of EOHHS with respect to Covered Individuals; and

Reporting to EOHHS information on cost avoidance and recovery amounts.

Retain any payments recouped from Network Providers as a result of the discovery of TPL, deposit them into the Direct Service Reserve Account (DSRA) (see **Section 10.12.A**) and use all such recoveries to offset BHP expenditures related to the delivery of BH Covered Services.

Unless otherwise directed by EOHHS, coordinate the Behavioral Health benefits of Covered Individuals with TPL with the other insurance resource, such as Medicare or commercial insurance, as described in **Section 2.3.D.1**. In

order to meet this requirement, the Contractor shall have all necessary changes to its operations in place by the Service Start Date, and shall continue to make all appropriate changes to its operations in compliance with any new policies from the EOHHS TPL Unit, including but not limited to changes to the following:

Management information systems;

Claims authorization systems;

Claims payment systems;

Staffing within the Claims Operation Department; and

Reporting.

Claims Payment Requirements for Covered Individuals under Age 21 with TPL

The Contractor shall ensure that:

Providers who provide BH Covered Services to Covered Individuals with TPL make diligent efforts to identify and obtain payment from all other liable parties, including insurers, as described in 130 CMR 450.316;

If a third-party resource is identified after the Provider has already billed and received payment from the Contractor, the Provider promptly returns any payment it received from the Contractor and ensure that the Provider bills all third-party resources before resubmitting a Claim to the Contractor;

Providers who submit Claims for Covered Individuals who have Medicare in addition to Medicaid:

bill the Medicare fiscal intermediary or carrier in accordance with their billing rules, including using the appropriate Medicare claim form and format;

accept assignment according to Medicare instructions; and

follow the Contractor's billing instructions, including any billing instructions specific to Medicare crossover claims.

It does <u>not</u> pay Providers:

who do not make diligent efforts to obtain payment from other liable parties; or

for services provided to a Covered Individual, if on the date of service the Covered Individual had other health insurance, including Medicare, that may have covered the service, and

the Provider did not participate in or resort to the Covered Individual's other insurance plan, including Medicare.

The Contractor shall establish the following payment limitations:

Payment shall not exceed the Covered Individual's liability, including co-insurance, deductibles and copayments; or the Provider's charges or the Contractor's payment amount, whichever is less; and

For Covered Individuals under 21 with Medicare, the payment amount shall not exceed the coinsurance and deductible amounts as reported on the explanation of benefits or remittance advice from Medicare; the Contractor's payment amount, or the Medicare-approved amount.

The terms of this Section 2.3.D. apply to Applied Behavioral Analysis services provided to Covered Individuals.

Covered Individuals – No Liability for Payment

The Contractor shall ensure, in accordance with 42 USC § 1396u-2(b)(6) and 42 CFR 438.106, that a Covered Individual is not held liable for:

Debts of the Contractor, in the event of the Contractor's insolvency;

BH Covered Services provided to the Covered Individual in the event that:

the Contractor fails to receive payment from EOHHS for such services; or

a Provider fails to receive payment from EOHHS or the Contractor for such services; or

Payments to a Network Provider in excess of the amount that would be owed by the Covered Individual if the Contractor had directly provided the services.

Any cost-sharing imposed on Covered Individuals shall be in accordance with 42 CFR 447.50 through 447.60.

Provider Preventable Conditions

The Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 CFR 434.6(a)(12), 42 CFR 438.6(f)(2), and 42 CFR 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:

The Contractor shall <u>not</u> pay a Provider for a Provider Preventable Condition.

The Contractor shall require, as a condition of payment from the Contractor, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 CFR 447.26(d) and as may be specified by the Contractor and/or EOHHS.

The Contractor shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.

A Contractor may limit reductions in Provider payments to the extent that the following apply:

The identified Provider Preventable Condition would otherwise result in an increase in payment.

The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition.

The Contractor shall ensure that its non-payment for Provider Preventable Conditions does not prevent Enrollee access to services.

Reporting

The Contractor shall submit to EOHHS all required reports related to the Contract's general administrative requirements, as described in this **Section 2** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

BEHAVIORAL HEALTH NETWORK RESPONSIBILITIES

Overview

The Contractor shall establish, operate and manage a Behavioral Health Provider Network to meet the Behavioral Health needs of Covered Individuals. The Contractor shall assure timely access for all Covered Individuals to the full range of BH Covered Services including outpatient, inpatient, 24-hour Diversionary, community Diversionary, and Emergency Services.

The Contractor shall manage its Provider Network in accordance with the Contract between the Contractor and EOHHS, as well as with the terms of its Provider Agreements with the Network Providers in its Behavioral Health Provider Network.

The Contractor shall meet its responsibilities under this Contract while adhering to the following key principles of Behavioral Health Provider Network management:

- The use of data in decision-making;
- Adherence to a continuous quality improvement process between the Contractor and Network Providers that focuses on access, quality, value and Covered Individual outcomes;
- Promoting collaboration and alignment with state and federally funded services and programs and support of state agency missions;
- Recognizing the capacity of Covered Individuals and their families to access their strengths as part of their treatment and eventual recovery;
- Supporting and incorporating EOHHS health care reform initiatives, including PCMHI and those associated with payment reform;
- Improving the ability of the Behavioral Health Provider Network to meet all of the health needs of Covered Individuals through strengthened collaboration with PCCs, Emergency departments, specialty medical providers, pharmacies and inpatient hospital providers.

The Contractor shall actively solicit best practice models that achieve and exemplify these principles in its programs and shall submit to EOHHS proposals to establish and replicate such programs.

Network Development

Management Strategy

The Contractor shall:

Beginning on the Service Start Date, develop and implement a strategy to manage the Provider Network with an emphasis on the following:

Access to care for Covered Individuals;

Quality of care;

Application of principles of rehabilitation and recovery to service planning and service delivery;

Reduction of health disparities (see **Section 3.1.H)**;

Measurement of outcomes for Covered Individuals over the course of receiving Behavioral Health Covered Services. The outcomes can range across the Covered Individual's full life domain;

Integration of Behavioral Health Covered Service delivery with medical services provided by the Enrollee's PCC or other key health care Providers; and

Cost-effectiveness of the delivery of BH Covered Services.

Ensure that its management strategy includes at least the following:

A systematic plan for utilizing Network Provider profiling and benchmarking data to identify and manage Network Providers who fall below established benchmarks and performance standards, and to replicate practices of Network Providers who consistently exceed benchmarks and performance standards;

A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward improvement goals;

Utilization of on-site visits to Network Providers at all Levels of Care, to support quality improvement efforts and benchmarking data; and

Steps to ensure Network Provider compliance with the Contractor's performance specifications for each BH Covered Service.

Take appropriate management action, including the development and monitoring of corrective action plans for Network Providers whose performance is determined by the Contractor to be in need of improvement.

Take appropriate action related to Network Providers who are also MassHealth Providers, as follows:

Upon the Contractor's awareness of any disciplinary action or sanction taken against a Network Provider, either internally by the Contractor or by any oversight agency or any source outside of the Contractor's organization, such as the Board of Registration in Medicine, the Division of Registration, and the federal Centers for Medicare and Medicaid Services (CMS), immediately inform EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department of such action taken and work collaboratively with the Customer Services vendor to maintain a process to share such information.

If notified that MassHealth or another state Medicaid agency has taken an action or imposed a sanction against a Medicaid provider, including disenrollment of any

such provider from the Medicaid program, review the Provider's performance related to this Contract and take any action or impose any sanction that the Contractor determines is appropriate, including disenrollment from the Contractor's Provider Network.

In collaboration with and as further directed by EOHHS, develop and implement Network Provider quality improvement activities directed at ensuring that Network Providers:

use the CANS Tool (see **Section 3.5.B**) in their Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services for Covered Individuals under the age of 21; and

access and utilize the CANS IT System to input information gathered using the CANS Tool to identify whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

Propose by the Service Start Date, and implement subject to EOHHS approval, a Network management strategy to engage with PCCs, specialty Providers, high-volume prescribers, and hospital Emergency departments to improve access for Covered Individuals who may be under- or over-utilizing Behavioral Health services. The proposal shall include but is not limited to:

Ways to complement current EOHHS efforts, including the Controlled Substance Management Program, DPH's Prescription Monitoring Program and other programs initiated by the MassHealth Pharmacy Program; and

Methods for the Contractor's staff and its Behavioral Health Network Providers to use to identify Enrollees who may benefit from participation in the Care Management Program described in **Section 6.2**;

Propose methods the Contractor will use to engage foster parents and other individuals with physical custody of Children in the Care and/or Custody of the Commonwealth in such children's health care needs to ensure that they obtain Early and Periodic Screening, Diagnosis and Treatment (EPSDT), periodic and inter-periodic screens and Medically Necessary follow-up medical dental and Behavioral Health services; and

Propose methods the Contractor will use to establish and maintain specific supports for Providers of Behavioral Health, Primary Care, and specialty health care who provide MassHealth Covered Services to Children in the Care and/or Custody of the Commonwealth to ensure continuity of care for Children in the Care and/or Custody of the Commonwealth who change Providers due to changes in their foster care arrangements or for other reasons.

The Contractor's proposal may be accepted, rejected, or modified by EOHHS in whole or in part.

Establishment of Behavioral Health Provider Network

As of the Service Start Date, the Contractor shall have in effect and maintain a Network of Providers for the delivery of BH Covered Services set forth in **Appendix A-1**, in accordance with the terms of this Contract. To the extent that any provider in the Contractor's provider network is subject to the Emergency Medical Treatment and Labor Act (EMTALA), it must comply with the Act, which requires:

a. Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. 489.24(b).

b. As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.

The Contractor shall:

Make best efforts to ensure that all network providers from the previous BHP contract continue to participate in the Contractor's Provider Network and, accordingly, renew prior to the Service Start Date Provider Agreements with all such network providers.

Ensure that all Provider Agreements the Contractor initially executes with network providers from the previous BHP contract are for a term of at least one year.

Enter into Provider Agreements with each ESP identified in **Appendix A-3** to provide ESP Services and Youth Mobile Crisis Intervention Services and each Community Service Agency (CSA) identified in **Appendix A-2** to provide Intensive Care Coordination and Family Support and Training Services.

No later than one month prior to the Service Start Date, or as otherwise agreed to by EOHHS, submit to EOHHS for its review and approval the Contractor's initial Provider Network.

Ensure that in the event that network providers contracted with the previous BHP vendor refuse to participate in the Contractor's Network, there are sufficient Network Providers to deliver all BH Covered Services in accordance with the terms of this Contract.

Ensure that its Provider Network includes sufficient numbers of Network Providers with experience and expertise with the following Behavioral Health conditions:

Dual Diagnosis;

Serious and Persistent Mental Illness;

Post-traumatic stress disorder, especially among children and adolescents;

Severed Emotional Disturbance (SED) among children and adolescents;

Sex-offending behaviors;

Eating disorders; and

Autism.

Ensure its Provider Network includes sufficient numbers of Network Providers with experience and expertise with the following populations of Covered Individuals:

Persons with physical disabilities;

Persons with chronic illness(es);

Children, adolescents and their families;

Persons who are homeless, including children and families;

Children in the Care and/or Custody of the Commonwealth;

Young adults who are transitioning out of state-sponsored programs as they turn 22;

Persons with developmental disabilities;

Persons with brain injuries;

Persons with HIV/AIDS;

Pregnant women who are substance abusers;

Young children;

Older adults;

Persons from diverse cultural backgrounds, including persons whose primary language is not English;

Persons who are deaf or hard of hearing; and

Persons who are blind or visually impaired.

Provide coverage across all regions of the state.

Ensure the availability of the full range of BH Covered Services.

Provide access to BH Covered Services according to the standards set forth in Section 3.1.G.

Make best efforts to ensure that women- and minority-owned or -controlled agencies and organizations are represented in the Provider Network, and submit to EOHHS an annual written assessment of the results of such efforts each Contract Year.

In establishing the Provider Network, consider the following:

The anticipated MassHealth enrollment for Covered Individuals;

The expected utilization of services, taking into consideration the characteristics and health care needs of specific MassHealth populations enrolled with the Contractor;

The numbers and types (in terms of training, experience, and specialization) of Network Providers required to furnish the BH Covered Services;

The numbers of Network Providers who are not accepting new Covered Individuals; and

The geographic location of Network Providers and Covered Individuals, considering distance, travel time, the means of transportation ordinarily used by Covered Individuals, and whether the location provides physical access for Covered Individuals with disabilities. (See also **Section 3.1.G.**)

At its discretion, create a plan, subject to EOHHS review and approval, to selectively procure a Provider Network.

Ensure that such plan provides for procuring the Network in a fair and equitable manner, and in accordance with the requirements set forth in **subsections 12.a-e**, above.

Allow all interested providers, including independently practicing licensed social workers, licensed mental health counselors Licensed Alcohol and Drug Counselors 1 (LADC1), and licensed marriage and family therapists, to apply to become Network Providers.

Submit to EOHHS for review and approval the new Provider Network following a reprocurement.

Share with MassHealth-contracted Managed Care Organizations (MCOs) any changes and/or updates to the ESP Provider network prior to disseminating that information to all Covered Individuals. This provision does not require the Contractor to share with the MassHealth-contracted MCOs any information that pertains solely to individuals who are Covered Individuals or Uninsured Individuals or persons with Medicare only.

Share with MassHealth-contracted Managed Care Organizations (MCOs) any changes and/or updates to the list of CSAs prior to disseminating that information to all Covered Individuals. This provision does not require the Contractor to share with

the MassHealth-contracted MCOs any information that pertains solely to individuals who are Covered Individuals.

Ensure the following payment provisions are met:

i. Payments to Federally Qualified Health Centers (FQHCs) for services to Covered Individuals are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay to Federally Qualified Health Care Centers with which it contracts at least the amount MassHealth would pay for such services on a fee-for-service basis as specified in 114.3 CMR 6.03, excluding any supplemental rate paid by MassHealth to FQHCs.

ii. If the amount paid by a managed care entity to an Indian Health Care Provider that is not a Federally Qualified Health Center for services provided by the provider to an Indian Enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian Health Care Provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

The Contractor shall ensure its payments to any licensed hospital facility operating in the Commonwealth that has been designated as a critical access hospital under 42 U.S.C. 1395i-4 are in an amount equal to at least 101 percent of allowable costs under the Contractor's plan, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services

In Contract Year 2, the Contractor shall provide an aggregate rate increase totaling not less than Five Million Dollars ($5,000,000.00) to Network Providers. Such rate increases shall be effective no later than January 1, 2014. By April 15, 2014, the Contractor and EOHHS shall agree on a method of validating that the Contractor has established and is paying such increased rates. The Contractor shall take corrective action measures approved by EOHHS if EOHHS determines rate increases have not been implemented in accordance with this section.

In the initial procurement of ESP services for the Southeast Area:

(a) the Contractor shall issue a Request for Proposal (RFP) to procure ESP services for the Southeast;

(b) the Contractor will select winning bidders;

(c) at the direction of EOHHS, the Contractor shall execute provider agreements with each winning bidder for the Southeast Area that require providers to:

(i) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:
1. provided ESP services; and

2. were terminated as a result of DMH ceasing to provide such ESP services.

(ii) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees.

(iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate for those positions for which the duties are substantially similar to the duties performed by regular agency employees, as follows:

ESP Core Staffing Position	Substantially Comparable DMH Position	Minimum Wage Rate under MGL c.7 §54(2)	Suggested Salary for Positions not comparable to DMH Positions
ESP Director	Clinical Social Worker (D)	$62,202.14	
ESP Director	Psychologist IV	$77,085.06	
QM/ RM Director	Manager VI	$57,071.04	
Program Manager	Clinical Social Worker (D)	$62,202.14	
Clinical Supervisor	Clinical Social Worker (C)	$59,511.60	
Clinical Supervisor	Human Services Coordinator (D)	$56,612.40	
Psychiatry	N/A		$221,700.00
Psychiatry After-Hours Adult Consult	N/A		$67,500.00
Psychiatry After-Hours Child Consult	N/A		$67,500.00
Nursing Manager RN	Registered Nurse IV	$62,751.26	
Nursing Manager RN	Registered Nurse V	$68,265.34	
Nursing RN	Registered Nurse II	$57,395.26	
Nursing RN	Community Psychiatric Mh Nurse	$62,751.60	
Nursing LPN	Licensed Practical Nurse I	$40,513.20	
Nursing LPN	Licensed Practical Nurse II	$42,955.38	
Certified Peer Specialist	Mental Health Coordinator I	$44,380.18	
BS w/CPS preferred	Human Services Coord (A/B)	$48,911.10	
BS Milieu	Mental Health Worker I	$30,146.74	
BS Milieu	Mental Health Worker II	$32,262.62	
BS Milieu w/CPS pref.	Human Services Coord (A/B)	$48,911.10	
Paraprofessional (Family Partner)	Mental Health Coordinator I	$44,380.18	
MS Triage Clinician	Human Services Coordinator (C)	$53,934.40	
MS Triage Clinician	Social Worker (C)	$51,539.80	
MS Clinicians	Human Services Coordinator (C)	$53,934.40	
MS Clinician Mobile	Human Services Coordinator (C)	$53,934.40	
MS Clinician Mobile	Clinical Social Worker (A/B)	$53,934.40	
MS Clinician Mobile	Clinical Social Worker (C)	$59,511.60	
Safety Staff	Mental Health Worker I	$30,146.74	
Admin. Assistant	Administrative Assistant I	$40,405.15	
Admin. Assistant	Clerk III	$33,460.70	

(iv) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons.
(v) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

Contract Provisions of Behavioral Health Provider Network

The Contractor shall:

Effective January 1, 2014, the Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for Behavioral Health Covered Services as most recently adopted by the American Medical Association and CMS; and shall pay no less than the MassHealth rate for such CPT codes. Except as otherwise provided in this Contract, develop proposed Network Provider payment rates for all services;

Unless otherwise agreed to by EOHHS, inform EOHHS of proposed rate changes prior to implementing them, executing Provider Agreements, or entering into any other arrangements with Network Providers;

Execute and maintain for the term of the Contract written Provider Agreements with a sufficient number of appropriately credentialed, licensed or otherwise qualified Network Providers to provide Covered Individuals with all Medically Necessary BH Covered Services;

Prior to distributing or executing any Provider Agreements or any amendments thereto, submit standard language for any such Agreement to EOHHS for approval;

Ensure that all Provider Agreements include provisions:

requiring Network Providers to accept as payment in full the Contractor's payment for BH Covered Services provided to Covered Individuals;

prohibiting Network Providers from charging Covered Individuals in full or in part for any service provided under the Contract or imposing any financial penalties on them, including charges for canceling or missing appointments, and as further set forth in **Section 2.3.E**;

stating the following:

"Providers shall not seek or accept payment from any Covered Individuals for any BH Covered Service rendered, nor shall providers have any claim against or seek payment from EOHHS. Instead, providers shall look solely to the (Contractor's name) for payment with respect to BH Covered Services rendered to Covered Individuals. Furthermore, providers shall not maintain any action at law or in equity against any Covered Individuals or EOHHS to collect any sums that are owed by the

(Contractor's name) under the Contract for any reason, even in the event that the (Contractor's name) fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Contract (where "Contract" refers to the agreement between the Contractor and any subcontractor and where "provider" refers to the subcontractor, including Network Providers and non-Network Providers with whom the Contractor is contracting)."

notwithstanding the provisions of subsections **5.a** and **b**, requiring Network Providers to charge Covered Individuals copayments in accordance with EOHHS's copayment regulations, at the direction of EOHHS;

prohibiting Network Providers from denying any BH Covered Service to a Covered Individual for failure or inability to pay any charge, or to a Covered Individual who, prior to becoming eligible for MassHealth services, incurred a bill that has not been paid;

requiring any Network Provider to notify the Contractor if it has reason to be considering insolvency or is otherwise financially unsound. The Contractor shall notify EOHHS within one business day of receipt of such financial notification;

requiring Network Providers of mental health Inpatient Services to accept for admission all Covered Individuals in need of inpatient admissions who are referred by ESPs, regardless of the availability of insurance, capacity to private pay, or clinical presentation;

prohibiting Network Providers from engaging in any practice with respect to any Covered Individual that constitutes unlawful discrimination on the basis of health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulation, including but not limited to 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90; and

requiring Network Providers to collaborate with EOHHS health care reform initiatives, including but not limited to payment reform and the Patient-Centered Medical Home Initiative, as directed by the Contractor.

clearly stating the Provider's EMTALA obligations and are not creating any conflicts with hospital actions required to comply with EMTALA.

As directed by EOHHS, ensure that all Provider Agreements with Network Provider clinicians who provide Behavioral Health services to Covered Individuals under the age of 21 in certain Levels of Care (including Diagnostic Evaluation for Outpatient Therapy (Individual Counseling, Group Counseling, and Couples/Family Counseling), Inpatient Psychiatric Services, and Community-Based Acute Treatment Services) require that they:

Become certified in the use of the Child and Adolescent Needs and Strengths (CANS) Tool for Behavioral Health diagnostic evaluations (see also **Section 3.5**), and recertified in its use every two years;

Use the CANS Tool whenever they deliver a Behavioral Health Clinical Assessment for a Covered Individual under the age of 21, which shall include using the CANS Tool during initial Behavioral Health Clinical Assessments and, at a minimum, every 90 days thereafter during ongoing treatment, and also as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations, and Community-Based Acute Treatment Services as described in **Appendix A-1**; and

Subject to consent, if required, by the Covered Individual, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT System the information gathered using the CANS Tool and the determination whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

Clinicians covered by this requirement include psychiatrists, psychiatric nurse mental health clinical specialists, psychologists, licensed independent clinical social workers (LICSWs), licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs), Licensed Alcohol and Drug Counselors 1 (LADC1), and unlicensed master's-level clinicians working under the supervision of a licensed clinician. If EOHHS determines that other types of clinicians who provide Behavioral Health Covered Services to Covered Individuals under the age of 21 in additional Levels of Care are also subject to the provisions of this section, the Contractor shall also include these provisions in such clinicians' Network Provider Agreements, as directed by EOHHS.

Ensure that all Provider Agreements with Community Service Agencies require that all intensive care coordinators of all levels:

Become certified in the use of the CANS Tool and recertified every two years;

Use the CANS Tool during the comprehensive home-based assessment that is part of the initial phase of intensive care coordination and, at a minimum, every 90 days thereafter during ongoing care coordination, and as part of Discharge Planning from the Intensive Care Coordination service; and

Subject to consent by the Covered Individual, parent, guardian, custodian or other authorized individual, as applicable, enter into the CANS IT System the information gathered using the CANS Tool and the intensive care coordinator's determination of whether the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

When requested, provide for a second opinion from a qualified health care professional within the Provider Network or arrange for the Covered Individual to obtain one outside the Provider Network, if a qualified in-

network health care professional is not available, at no cost to the Covered Individual;

Ensure that its Network Providers comply with state and federal regulations that prohibit a health care facility from charging or seeking payment for services provided as a result of the occurrence of certain Serious Reportable Events, as well as any additional requirements or limitations placed on payment by EOHHS;

Ensure that its Provider Agreements specify that:

No payment shall be made by the Contractor to a Provider for a Provider Preventable Condition; and

As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 CFR 447.26(d) and as may be specified by the Contractor.

Contract Provisions for Network Providers that Perform Behavioral Health Clinical Assessments

The Contractor shall:

Require of all Network Providers that have clinicians who provide Behavioral Health Clinical Assessments and conduct Discharge Planning from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services, using the CANS Tool in accordance with **Sections 3.1.C.6** and **7,** that they have Virtual Gateway accounts and a high-speed internet or satellite internet connection to access the CANS IT System; except that the Contractor may have policies and procedures approved by EOHHS to grant temporary waivers of these requirements on a case-by-case basis.

Require of all Network Providers that provide Behavioral Health Clinical Assessments and perform Discharge Planning from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services, using the CANS Tool in accordance with **Sections 3.1.C.6** and **7**, that they seek consent from the Covered Individual, parent, guardian, custodian or other authorized individual, as applicable, using the form of consent approved by EOHHS, before entering the information gathered using the CANS Tool into the CANS IT System.

Require Network Providers that obtain such consent to enter the information gathered using the CANS Tool and the determination of whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance into the CANS IT System.

Require Network Providers that do not obtain such consent to enter only the determination of whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance into the CANS IT System.

Health Care Reform, Including Payment Reform

The Contractor shall collaborate with EOHHS upon request on the development and implementation of payment reform initiatives for its Network Providers. Such initiatives may include

Global payments rather than Fee-for-Service payments;

Primary Care Payment Reform initiatives;

Pay for Performance; and

Other outcome-based payment methods.

Non-Network Providers

The Contractor shall:

Permit Covered Individuals who reside in a rural service area, as identified by EOHHS in accordance with the provisions of 42 CFR 412.62(f)(1)(ii) (currently, Dukes County and Nantucket County), to obtain Medically Necessary BH Covered Services from non-Network Providers under the following circumstances:

The Covered Individual is unable to obtain the same service or to access a Network Provider with the equivalent training, experience, and specialization within the Provider Network;

The Network Provider from whom the Covered Individual seeks the service is the main source of service to the Covered Individual, except that the Covered Individual shall have no right to obtain services from a Provider outside the Provider Network if the Contractor gave the Provider the opportunity to participate in the Provider Network under the same requirements for participation applicable to other Providers and the Provider chose not to join the Provider Network or did not meet the necessary requirements to join the Provider Network;

The only Network Provider available to the Covered Individual in the Provider Network does not, because of moral or religious objections, provide the service the Covered Individual seeks; or

The Covered Individual's Network Provider or other provider determines that the Covered Individual needs a service(s), and that the Covered Individual would be subjected to unnecessary risk if he/she received the needed services separately and not all of the related services are available within the Provider Network.

Adequately and timely provide all Covered Individuals with access to non-Network Providers for BH Covered Services for as long as the Contractor is unable to provide them. The Contractor shall negotiate and execute written single-case agreements or arrangements with non-Network Providers, when necessary, to assure access to BH Covered Services.

Ensure that non-Network Providers' agreements or arrangements include the provisions required in **Section 3.1.C.4**.

Ensure that service authorizations and Utilization Management protocols, Claims submissions and Internal Appeals policies for non-Network Providers are consistent with the terms in the Contractor's Network Provider Agreements.

Access and Availability of Behavioral Health Provider Network

The Contractor shall:

Permit Covered Individuals to self-refer to any Network Provider of their choice for Medically Necessary Behavioral Health Covered Services.

Ensure adequate physical and geographic access to BH Covered Services for Covered Individuals.

Ensure Covered Individuals have access to a choice of at least two Network Providers who provide BH Covered Services to the extent that qualified, willing Network Providers are available.

Assure EOHHS that it has the capacity to service expected enrollment of Covered Individuals in accordance with the access standards specified in **Sections 3.1.G.6** and **7** by submitting reports specified in **Appendix E-1**, on a quarterly basis and whenever there is a significant change in operations that would affect the adequacy and capacity of services. "Significant changes" include, but are not limited to:

changes in MassHealth Covered Services;

enrollment of a new population in the Contractor's plan;

changes in benefits; and

changes in Network Provider payment methodology.

If the Contractor does not comply with the access standards specified in **Sections 3.1.G.6** and **7**, the Contractor shall take corrective action necessary to comply with such access standards.

Ensure access to BH Covered Services in accordance with state and federal laws for persons with disabilities by ensuring that physical and communication barriers do not inhibit them from obtaining services under the Contract.

Monitor the practice of creating waiting lists for Covered Individuals who seek outpatient BH Covered Services. If the Contractor determines that a Network Provider has established a waiting list, the Contractor shall create a plan to identify such Network Providers and help them reduce such waiting lists, with the goal of eliminating them. Such activity shall include but not be limited to the Contractor directly assisting Covered Individuals

to find an appropriate alternative Provider. The Contractor shall further ensure that:

Waiting lists are established and maintained in such a way as to not violate the provisions of M.G.L. c. 151(B), including waiting for appointments after the initial appointment; and

Network Providers with waiting lists refer Covered Individuals to other qualified Network Providers who do not have waiting lists.

Execute and maintain Provider Agreements with Network Providers to ensure that, at a minimum, 90 percent of Covered Individuals have access to all Medically Necessary Behavioral Health Covered Services according to the following standards:

Inpatient Services within 60 miles or 60 minutes' travel time from the Covered Individual's residence, whichever requires less travel time;

ESP Services as available based on the ESP Provider list in **Appendix A-3**; and

Intensive Care Coordination and Family Support and Training Services provided by Community Service Agencies as available based on the CSA Provider list in **Appendix A-2**;

Other Intensive Home and Community-Based Services, which require Network Providers to travel to the Covered Individual's residence for services, must be available in all cities and towns in the Commonwealth; and

All other BH Covered Services within 30 miles or 30 minutes' travel time from the Covered Individual's residence, whichever requires less travel time.

Notwithstanding the generality of the foregoing, the Contractor shall ensure access to at least one Network Provider, except ESPs, of each BH Covered Service in every geographic region of the state with more than 2.5 percent of Covered Individuals or, as determined by EOHHS, to the extent that qualified, interested Providers are available.

Ensure that access to Behavioral Health Services for Covered Individuals is consistent with the degree of urgency, as follows:

Emergency Services shall be provided immediately (respond to call with a live voice; face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present at any qualified Provider, whether a Network Provider or a non-Network Provider;

ESP Services shall be provided immediately on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present, including covered individuals, uninsured individuals and persons covered by Medicare only;

Urgent Care Services shall be provided within 48 hours; and

All other care shall be provided within 14 calendar days.

Offer Covered Individuals who require readmission to Inpatient Mental Health Services readmission to the same Network Provider when there is a bed available in that facility.

Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to individuals with commercial insurance, or comparable to Medicaid Fee-for-Service if the Network Provider serves only MassHealth Members.

The Contractor may request an exception to the access standards set forth in this **Section 3.1.G** by submitting a written request to EOHHS. Such request shall include alternative standards that are equal to or better than the usual and customary community standards for accessing care. Upon approval by EOHHS, the Contractor shall notify Covered Individuals in writing of such alternative access standards.

Health Disparities

The Contractor shall ensure that:

Multilingual Network Providers and, to the extent that such capacity exists in a region, all Network Providers understand and comply with their obligations under state and federal law to assist Covered Individuals with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

Network Providers and interpreters/translators are available for those who are deaf or hearing-impaired, to the extent that such capacity exists within each region.

Its Network Providers are responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, the Homeless, disabled individuals and other special populations served under the Contract.

Perform at the beginning of the Contract, and thereafter at least every three years, an in-depth demographic analysis with Network Providers, as well as more robust data analysis, to identify health disparities and develop mitigation strategies based on current Network Provider capacity as described in subsections **1-3**, above; and build additional Network capacity based on the analysis.

Implement the identified mitigation strategies as approved by EOHHS.

Network Provider Credentialing

Credentialing Process

The Contractor shall implement written policies and procedures that comply with the EOHHS requirements set forth below regarding the selection, retention, and exclusion of

Providers from the Provider Network. Such written policies and procedures shall, at a minimum:

Require Network Providers to meet the Credentialing Criteria approved by EOHHS, unless the Contractor establishes that such criteria should be waived pursuant to **Section 3.1.I.3**.

Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Network Providers and all other licensed or certified Network Providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13. The basic components of these processes shall include a review of the following:

licensing, accreditation, certification, training, specialty board eligibility or certification;

current status of professional license, restrictions, and history of any loss of licensure in any state;

DEA number and copy of certification, where applicable;

hospital privileges, name of hospitals, and scope of privileges, where applicable;

malpractice insurance, carrier name, amount of coverage, copy of the face sheet, and scope of coverage;

malpractice history, pending claims, and successful claims against the Provider;

record of continuing professional education;

Medicare, Medicaid, federal tax identification number, and Social Security numbers;

location, service area and telephone numbers of all offices, hours of operation, and provisions for Emergency care and backup;

areas of special experience, skills and training;

cultural and linguistic capabilities;

review of Covered Individual satisfaction and any complaints made or Grievances filed against the Network Provider within the past two years;

physical accessibility for persons with disabilities;

reference check;

for facility-based Network Providers, a site visit and evidence of a training program for staff on the appropriate and safe use of restraint and seclusion to the extent that the facility's license permits the use of seclusion;

for Network Providers of 24-hour services, evidence of a training program for staff on the appropriate and safe use of restraint and seclusion.

Ensure that all Network Providers are credentialed prior to becoming Network Providers and that a site visit is conducted with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations;

Ensure that physician Network Providers and other licensed or certified professional Network Providers maintain current knowledge, ability, and expertise in their practice area(s) by, at minimum, obtaining continuing education units (CEUs) and participating in other training opportunities, as appropriate.

Ensure that Network Providers are recredentialed every three years, at a minimum, and take into consideration various forms of data, but not limited to, Grievances, results of quality reviews, Covered Individual satisfaction surveys, and Utilization Management information.

Designate the Contractor's department(s) and staff who will be directly responsible for credentialing and recredentialing Network Providers.

To the extent permitted by law and upon request, provide Covered Individuals or their legal guardians with information in the Network Provider database, with the exception of the information described in subsections **b.5)**, **6)**, **8)**, **14)**, **15)** and **16)** above.

Ensure that that the credentialing process does not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

Not authorize any Network Providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Covered Individuals, and deny payment to such Network Providers for any service provided.

The Contractor shall, at a minimum, check the BORIM website at least once per month and the U.S. Department of Health and Human Services Office of the Inspector General's (OIG) List of Excluded Individuals Entities (LEIE) or Medicare Exclusion Database (MED) websites before the Contractor contracts with a Provider to become part of its Provider Network, at the time of a Provider's credentialing and recredentialing, and at least monthly.

The Contractor shall notify a Network Provider within three business days that, due to its MassHealth, Medicare, or another state's Medicaid program termination or suspension or a state or federal licensing action, such Network Provider is terminated or suspended, as appropriate, from the Contractor's Provider Network, and is no longer eligible to treat Covered Individuals. The Contractor shall have a process in place to immediately effectuate such termination or suspension.

When the Contractor terminates, suspends, or rejects a Network Provider from its Network based on such Provider's termination or suspension with MassHealth, Medicare, or another state's Medicaid program, a state or federal licensing action, or based on any other independent action, the Contractor shall notify EOHHS of the Network Provider termination, suspension or rejection, and the reason thereof, within three business days.

On an annual basis, the Contractor shall submit to EOHHS a certification checklist confirming that it has implemented the actions necessary to comply with this section.

This section does not preclude the Contractor from suspending or terminating Network Providers for cause prior to such Network Provider's ultimate suspension and/or termination by EOHHS from participation in MassHealth.

Not contract with a Provider, or otherwise pay for any items or services furnished, directed or prescribed by a Provider that has been excluded from participation in federal health care programs by the OIG under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901.

Ensure that no Network Provider engages in any practice with respect to any Covered Individual that constitutes unlawful discrimination under any other state or federal

law or regulation, including but not limited to practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.

Search for the names of parties disclosed during the credentialing process in the BORIM, OIG LEIE, and Medicare MED exclusion or debarment databases and the MassHealth exclusion list, and do not contract with parties that have been terminated from participation under Medicare or another state's Medicaid program.

Notify EOHHS when a Network Provider fails credentialing or re-credentialing because of a program-integrity reason, including those reasons described in this **Section 3.1.I.1**, and provide information required by EOHHS or state or federal laws, rules, or regulations.

Demonstrate to EOHHS, by reporting annually in accordance with **Appendix E-1**, that all Network Providers within the Contractor's Provider Network are credentialed according to this **Section 3.1.I.1**.

Network Provider Qualifications

The Contractor shall:

Execute Provider Agreements or enter into other arrangements for BH Covered Services only with facility-based Providers that satisfy the following criteria:

They are financially stable, as determined by the Contractor;

They have established and maintain a Quality Management program, as described in **Section 8**;

They comply with policies and regulations with respect to patient rights and privileges, as applicable;

They maintain records consistent with current professional standards and EOHHS regulations, as well as systems for accurately documenting the following information for each Covered Individual receiving BH Covered Services:

demographic information;

clinical history;

Behavioral Health Clinical Assessments;

treatment plans;

services provided;

contacts with Covered Individuals' family, guardians, or significant others; and

treatment outcomes;

Are responsive to linguistic, cultural and other unique needs of any member of a cultural, racial or linguistic minority, or other special population in the region in which they provide services;

Have the capacity to communicate with Covered Individuals in languages other than English, when necessary, as well as with those who are deaf or hearing-impaired;

Satisfy all federal and state requirements for affirmative action;

Satisfy all federal and state legal requirements regarding the Provider's physical plant and premises;

Comply with all applicable anti-discrimination requirements described in 42 CFR 438.6(d)(3) and (4);

Comply with all other applicable state and federal laws;

Meet the Credentialing Criteria, unless the Contractor establishes that such criteria should be waived pursuant to **Section 3.1.I.3**; and

Have been credentialed pursuant to the policies and procedures specified in **Section 3.1.I.1**.

Ensure that, in addition to the criteria set forth in subsection **a**, above, those facility-based Network Providers that are Network Providers of Inpatient Services are fully licensed by DMH and by DPH as applicable. In addition, ensure that such Providers:

Comply with DMH regulations concerning human rights set forth in 104 CMR 27.13 and 14 and 104 CMR 28.11, including ensuring that that human rights activities are overseen by a human rights committee and officer, and provide training for staff and education for Covered Individuals regarding human rights. To the extent permissible under **Section 14**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

Comply with DMH's regulations concerning restraint and seclusion (see **Section 3.2.A**, below). To the extent permissible under **Section 14**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

Submit to the Contractor evidence of implementation of the training programs described in subsections **b.2)** and **3)** as part of investigations of Serious Reportable Events, implementation of corrective action plans that involve human rights, and the use of restraint and seclusion;

Notify the DMH Licensing Unit of an inpatient Provider's non-compliance with these requirements and collaboratively determine whether additional Contractor action is appropriate; and

Develop organizational and clinical linkages with each of the high-volume referral source ESPs, as identified by EOHHS, hold regular meetings, and communicate with the ESPs on clinical and administrative issues, as needed, to enhance continuity of care for Covered Individuals;

Contractor activities to ensure compliance include informing the DMH Licensing Unit of inpatient units' non-compliance with these requirements and collaboratively determining if additional action by the Contractor is appropriate.

Preferentially execute Provider Agreements or enter into other arrangements for the provision of BH Covered Services with Providers that demonstrate a commitment to the principles of rehabilitation and recovery from mental illness and addiction, including a focus on recovery-oriented services, consumer and family involvement in program management, a strength-based approach to working with children and their families, and training for staff on such principles.

Credentialing Waiver Process

The Contractor shall:

Develop a proposal for a credentialing waiver process to allow certain Providers who do not meet all of the Contractor's Credentialing Criteria to be included in the Provider Network when there is an objective need for including those Providers (e.g., the Provider fills a cultural, linguistic, or geographic access need).

Ensure that no BH Covered Service is rendered at any time during the term of the Contract by any person, facility, agency or organization that does not meet all Credentialing

Criteria under this Contract, or any applicable law or regulation, unless EOHHS specifically waives in writing an applicable Credentialing Criterion, to the extent such waiver is within the authority of EOHHS.

Additional Behavioral Health Provider Network Requirements

Use of Restraint and Seclusion Techniques

The Contractor shall require Network Providers to have all applicable licenses and comply with all applicable laws and regulations concerning restraint and seclusion, including without limitation:

DMH regulations concerning seclusion and restraint at 104 CMR 27.12 and physical restraint at 104 CMR 28.05, or any successive regulation; and

Federal regulations at 42 CFR 441.151 subpart D and 42 CFR 483 subpart G.

The Contractor shall monitor the Network Providers' compliance with the requirements of the laws and regulations set forth by DMH, as well as all other applicable laws and regulations.

To the extent permissible under **Section 14**, the Contractor shall notify EOHHS and the DMH Licensing Unit of non-compliance; and

The Contractor shall take all necessary corrective actions to correct non-compliance by Network Providers in collaboration with the DMH Licensing Unit.

Linkage with Consumer Initiatives, Recovery Initiatives, Natural Community Supports and Anonymous Recovery Programs

The Contractor shall manage the Behavioral Health Provider Network to align with other programs and services that support and complement Covered Individuals' participation in BH Covered Services and that promote Covered Individuals' recovery, empowerment, and use of their strengths and the family's strengths in achieving their clinical goals and improving their health outcomes.

The Contractor shall actively manage Network Providers to complement and integrate with the following formal and informal resources and programs:

Consumer Initiatives;

Rehabilitation programs that promote skill-building, supported employment and full competitive employment for Covered Individuals;

Natural community supports for Covered Individuals and their families; and

Anonymous recovery programs (e.g., 12-step programs) for Covered Individuals and their families.

The Contractor shall also work with its Network Providers to actively collaborate with other EOHHS-funded programs, including but not limited to:

DMH-funded programs, such as Community-Based Flexible Supports;

DCF-funded programs that support the safety, permanency and well-being of Children in the Care and Custody of the Commonwealth;

BSAS-funded programs for Covered Individuals, such as recovery homes to promote continuity of services for substance abuse from acute care to supportive and rehabilitative care and recovery supports;

DDS programs that involve rehabilitative and habilitative services for persons with developmental disabilities;

DYS programs that help clients stay in the community and avoid recidivism to DYS;

Other programs and initiatives within EOHHS, MassHealth and DPH related to PCC coordination and pharmacy management, including federal and state grant programs; and

Prevention and wellness programs at the state, regional and local level.

The Contractor shall demonstrate through its Network management plan and individual Network Provider Agreements the continued effort to work with Network Providers to access these resources and supports.

Compliance with Section 1202 of the ACA and 42 U.S.C 1396a(13)(C)

This **Section 3.2.C** implements Section 202 of the Affordable Care Act (ACA).

In the event that this Contract provides for payment of Primary Care services or vaccine administration, as defined in said Section 1202 and related regulations and subregulatory guidance, then the Contractor shall comply as follows:

As directed by EOHHS, and for services rendered on or after January 1, 2013, the Contractor shall set payment rates for primary care services provided by eligible Providers and for pediatric vaccines in accordance with Section 1202 of the ACA and 42 U.S.C. 1396a(13)(C), EOHHS policies, and all applicable federal and state laws, regulations, rules, and policies related to the implementation of such requirement. In the manner and frequency directed by EOHHS, the Contractor shall submit reports relating to this **Section 10.1.A.6**.

Notwithstanding the generality of the foregoing, the Contractor shall, in accordance with 42 CFR 438.6(c)(5)(vi), for payments for primary care services in calendar years 2013 and 2014 furnished to Enrollees under 42 CFR Part 447, subpart G:

1. Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 CFR Part 447, subpart G; and

2. Provide documentation to EOHHS, sufficient to enable EOHHS and CMS to ensure that provider payments increase as required by subsection 1.

Compliance with Federal BBA Requirements

Subcapitation and Physician Incentive Plans

The Contractor may, subject to EOHHS's prior review and approval and all applicable state and federal rules and regulations, including but not limited to the provisions of 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, negotiate and enter into arrangements to pay Network Providers on a subcapitated basis or operate a physician incentive plan.

The Contractor shall not engage in risk-sharing payment methodologies (i.e., non-Fee-for-Service arrangements) with its Network Providers without first submitting the proposed payment methodology to EOHHS for review and approval. Any Network Provider payment methodology that the Contractor proposes to EOHHS must satisfy the following minimum requirements:

Balance cost incentives with access and quality incentives; and

Ensure that those Network Providers for whom the Contractor proposes to use such payment methodologies are able to demonstrate the managerial, operational and financial capability to manage the proposed risk arrangement.

The Contractor shall comply, and shall ensure that its subcontractors comply, with all applicable requirements governing subcapitation arrangements and physician incentive plans. In accordance with the requirements of 42 CFR Parts 417, 434 and 1003, the Contractor shall ensure that:

No specific payment is made directly or indirectly to a Provider as an inducement to reduce or limit Medically Necessary services furnished to a Covered Individual; and

The applicable stop-loss protection, Covered Individual survey, and disclosure requirements of 42 CFR Part 417 are met.

Emergency and Post-stabilization Care Service Coverage

The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition in accordance with 42 CFR 438.114 and M.G.L. c. 118E, § 17A.

The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition regardless of whether the Provider that furnishes the services has a contract with the Contractor.

The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition, including cases in which the absence of immediate medical attention would not have:

placed the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

resulted in serious impairment to bodily functions; or

resulted in serious dysfunction of any bodily organ or part.

The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition if a representative of the Contractor instructed the Covered Individual to seek Emergency services.

The Contractor may not limit what constitutes a Behavioral Health Emergency medical condition on the basis of lists of diagnoses or symptoms;

The Contractor may require Network Providers to notify the Covered Individual's PCC of the Covered Individual's screening and treatment, but may not refuse to cover MassHealth Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition based on their failure to do so;

A Covered Individual who has an Emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient;

The attending emergency physician, or the Provider actually treating the Covered Individual, is responsible for transfer or discharge, and that determination is binding on the Contractor, if such transfer or discharge order:

is consistent with generally accepted principles of professional medical practice; and

is a covered benefit under the Contract.

The Contractor shall cover and pay for Post-stabilization Care Services that are MassHealth Covered Services in accordance with 42 CFR 438.114, 42 CFR 422.113(c), and M.G.L. c. 118E, § 17A.

Non-Network Emergency Service Coverage

The Contractor shall pay a non-Network Provider of Emergency Services an amount equal to the amount allowed under the state's Fee-for-Service rates less any payments for indirect costs of medical education and direct costs of graduate medical education. The Contractor shall ensure that the Covered Individual is not balance billed for the difference, if any, between such rate and the non-Network Provider's charges.

ESP Services

ESP Policies and Procedures

For ESP Providers under contract with the Contractor, the Contractor shall:

Ensure that the ESP Providers set forth in **Appendix A-3** provide all ESP Services as set forth in **Appendix A-1**, consistent with the Contractor's performance specifications;

Ensure that Covered Individuals and Uninsured Individuals and persons covered by Medicare only are provided with unrestricted access to ESP Services, including Adult and Youth Mobile Crisis Intervention, immediately in response to a Behavioral Health crisis, on a 24-hour basis, seven days a week;

Ensure that the response time for face-to-face evaluations by ESPs does not exceed one hour from notification of the need, or, in the case of referrals from hospital emergency departments, from the notification of readiness for evaluation by the ESP;

Ensure the 24-hour-a-day access or availability of clinicians in the ESPs who have special training or experience in providing Behavioral Health services for:

the full array of Behavioral Health conditions;

children and adolescents (clinicians providing ESP Services to children and adolescents must be child-trained clinicians who meet Youth Mobile Crisis Intervention competency standards as defined in the Contractor's performance specifications);

individuals with substance abuse disorders or a Dual Diagnosis;

individuals with intellectual disabilities, developmental disabilities, or autism spectrum disorders; and

the elderly.

Establish policies and procedures to ensure that ESPs provide Crisis Assessment and Intervention Services to all Covered Individuals prior to hospital admissions for Inpatient Mental Health Services to ensure that the Covered Individuals have been evaluated for diversion or referral to the least restrictive appropriate treatment setting. The Contractor's policies and procedures shall include:

requiring that the ESP located in the geographic area where the individual is physically located perform the Crisis Assessment and Intervention;

not requiring ESPs to obtain prior authorization to provide a Crisis Intervention and Assessment;

developing Contract standards, reviewed and approved by EOHHS annually, and monitoring the ESP Provider network's performance on diversion and inpatient admission rates, timeliness of assessment, and rate of community-based Emergency Encounters by establishing minimum standards and target/goals for diversionary rates; and

authorizing Medically Necessary BH Covered Services following a Crisis Assessment and Intervention.

Require and ensure that ESPs have arrangements, agreements or procedures to coordinate care with Network Providers, DMH area and site offices, DCF regional offices and DYS regional offices in the geographic area they serve;

For children and adolescents, have in place the following the ESP policies and procedures:

Ensure that each ESP has policies and procedures that include Youth Mobile Crisis Intervention Service;

Ensure that each ESP has arrangements with the major providers of children's residential services in the DMH, DCF, and DYS systems, as identified by the relevant agency's director for the applicable ESP service area; and

Require ESPs to arrange for Specialing Services, when children or adolescents are awaiting admission to a 24-hour Level of Care in a hospital Emergency Department setting, if such services are Medically Necessary to ensure safety when a youth is at risk of harming self or others. Specialing Services are a professional service provided by appropriately credentialed staff. For payment purposes, the Contractor shall not treat such Specialing Services as an ESP Encounter. If an overnight stay is required while the provider is searching for an inpatient bed, the Contractor shall consider requests from the ESP or Mobile Crisis Intervention (MCI) Provider, in consultation with the ED, for authorization to board the Covered individual on a pediatric medical unit.

Require and ensure that ESPs make all reasonable attempts to work with local police to develop models of mutual response to Behavioral Health Emergencies when needed.

Payment

The Contractor shall enter into or amend contracts with ESP Providers, using the ESP Provider rates set by DHCFP as the minimum rate.

ESP Administrative Oversight

The Contractor shall coordinate the administration and management of the ESP services for the Contractor's contracted ESP Providers under guidance from DMH and EOHHS. In this role the Contractor shall:

Ensure that all ESP Provider Agreements require ESPs to provide the services described in **Appendix A-1, Part III** to any individual who presents for such services in the following payer categories:

MassHealth (PCC Plan; MassHealth MCOs; FFS),

Commonwealth Care,

Uninsured Individuals, and

Medicare.

Facilitate annually, at least 10 in a 12-month Contract Year, or monthly if the Contract Year is less than 12 months, statewide meetings with Contractor-contracted ESP or MCI providers, and invite the participation of the DMH-operated ESP/MCI providers, to support consistency in service delivery.

Require ESPs to refer adult Uninsured Individuals and persons with Medicare-only to available beds in psychiatric units of general hospitals first, if beds in such hospitals are available and clinically appropriate, before referring them to psychiatric hospitals;

After a court clinician has conducted a psychiatric evaluation pursuant to M.G.L. c. 123 § 12(e), ensure that upon request of such court clinician:

ESPs provide Crisis Assessment and Intervention Services to all Covered Individuals (including onsite mobile evaluations at the court).

Identify to the court clinician appropriate diversions from inpatient hospitalization, and assist court clinicians to develop any plan to utilize such diversions. Nothing in this provision shall be construed as establishing a court clinician evaluation as a prerequisite to an onsite mobile evaluation at the court; and

If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), ESPs conduct a search for an available bed, making best efforts to locate such a bed for the individual by 4:00 p.m. on the day of the issuance of such commitment order. If a bed is not found by 4:00, the ESP will work with the court clinician to ensure appropriate disposition and transfer of the individual to a safe place outside of the court setting.

Adopt the existing Massachusetts Behavioral Health Access System, or develop and implement its own process that helps ESPs and hospital Emergency departments to search on-line for available Inpatient Mental Health Services Inpatient Substance Abuse Services, 24-hour Diversionary Services and CBHI Services.

The system shall provide on-line web access on a 24-hour basis seven days a week.

The Contractor shall ensure that the web-based system is updated at least once every eight hours for 24-hour services, and at least weekly for CBHI Services (Intensive Care Coordination, In-Home Behavioral Services, Therapeutic Mentoring, In-Home Therapy).

The Contractor shall develop an annual report (with specifications subject to EOHHS review and prior approval) that tracks utilization of the Massachusetts Behavioral Health Access System and other data as agreed to by the parties.

Encounter Forms

The Contractor shall:

Create an ESP Encounter form to report on ESP Services described in **Appendix A-1**;

Require ESPs to complete and submit the electronic EOHHS-approved ESP Encounter form for each individual they serve; and

Work with EOHHS to transfer the records from the existing Encounter database, which includes the information contained in the ESP Encounter forms.

Children's Behavioral Health Initiative (CBHI)

CBHI Training and Quality Improvement

The Contractor shall, as directed by EOHHS, take all steps and perform all activities necessary to improve the CBHI, which shall include, without limitation, participation in meetings and workgroups, including joint workgroups with all MassHealth Managed Care payers to develop coordinated network management and quality improvement strategies for all payers on these services and other tasks as directed.

With EOHHS approval, the Contractor may secure consultant resources to support ongoing implementation, training and quality improvement of CBHI Services. Such consultant resources may recommend network management, Utilization Management and Quality Management strategies or identify strategies to improve the quality of Network Provider organizations in their delivery of CBHI Services. Consultants may also provide trainings or coaching to Providers of CBHI Services, including to providers within the networks of MassHealth Managed Care entities who provide CBHI Services, or perform outreach and education to prospective families in need of CBHI Services.

Use of the CANS Tool

The Contractor shall ensure the continued use of the CANS Tool by all Behavioral Health Service providers that are required to use it (see **Section 3.1.C.6**), as directed by EOHHS. The Contractor shall:

Propose for EOHHS approval rates for initial Behavioral Health Clinical Assessments using the CANS Tool for Covered Individuals under the age of 21; Contractor shall allow Network Providers to bill two units of this service to allow for the additional time required to complete this type of evaluation.

Ensure that it pays only Network Providers whose servicing clinicians are certified in the CANS Tool for providing Behavioral Health Clinical Assessments using the CANS Tool;

Ensure that Providers of Behavioral Health Clinical Assessments using the CANS Tool bill for these assessments. The review and updating of the CANS assessment that is required at a minimum every 90 days for Covered Individuals in ongoing individual, group, or family therapy is part of the treatment planning and documentation, and as such, is not a separately billable service.

Ensure that its customer services representatives who respond to questions from Network Providers are informed about the requirements and process for applicable Network Providers to become trained and certified in administering the CANS Tool and can respond to questions from Network Providers about these requirements and processes. The Contractor shall provide training to its newly hired and existing customer services representatives about when, where and how Network Providers obtain CANS training and certification, and shall provide refresher trainings as directed by EOHHS and as the Contractor determines is necessary.

Ensure that its customer services representatives who are assigned to respond to inquiries from Covered Individuals are informed about the use of the CANS and other CBHI Services, and can respond to Covered Individuals' questions about them. The Contractor shall provide training to its newly hired and existing customer services representatives about the CANS Tool and how it is generally used in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services, and Transitional Care Units.

As directed by EOHHS, ensure that Covered Individual materials, including but not limited to the Handbook for Covered Individuals, describe the CANS Tool and its use in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services for Covered Individuals under the age of 21.

As directed by EOHHS, ensure that appropriate Network Provider materials exist to describe the CANS Tool, the requirements and process for CANS Tool training and certification, and the CANS IT System.

Be able to access and use the CANS IT System and data contained therein to integrate with clinical data, and use in reporting as directed by EOHHS.

Participate in any testing or development processes necessary for EOHHS to develop and refine the CANS IT System.

CBHI Service Rates

As directed by EOHHS, the Contractor shall contract by the Service Start Date with the existing network of Providers to provide the following CBHI Services, when Medically Necessary, to Covered Individuals in the Coverage Types specified, unless otherwise directed by EOHHS. For each of these services the Contractor shall establish Network Provider rates at or above the rate floor set by DHCFP and shall use procedure codes as directed by EOHHS to provide payment for such services.

Intensive Care Coordination: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

Family Support and Training Services: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

Therapeutic Mentoring Services: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth; and

In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support) to all Covered Individuals under age 21.

As directed by EOHHS, the Contractor shall contract with ESP Providers to provide Youth Mobile Crisis Intervention Services, when Medically Necessary, to all Covered Individuals under the age of 21. For this service, the Contractor shall establish Network Provider rates at or above the rate floor set by DHCFP and shall use procedure codes as directed by EOHHS to provide payment for such services.

CBHI Service Authorization

The Contractor shall inform EOHHS in writing of its authorization procedures for Behavioral Health Covered Services for Covered Individuals under 21 who are receiving CBHI Services, and of any changes to such authorization procedures prior to their implementation. The Contractor shall assist Network Providers in learning how to utilize Contractor's authorization procedures for CBHI Services. The Contractor shall monitor its authorization procedures to ensure that the procedures provide for timely access to services. In the event that Contractor's authorization procedures for CBHI Services result in delays or barriers to accessing Medically Necessary BH Covered Services, the Contractor shall modify such authorization procedures. The Contractor shall coordinate with other MassHealth payers to publish a single document that describes the authorization procedures for all MassHealth payers for these services.

The Contractor shall ensure that the authorization procedures established for Intensive Care Coordination (ICC) and Family Support and Training (FS and T) allow for at least the first 28 days of services to be provided without prior approval. The Contractor may establish notification or registration procedures during the first 28 days of ICC.

The Contractor shall ensure that its authorization procedures comply with all provisions of **Section 4.2** of the Contract and, in addition, that all authorization approvals for ICC and FS and T are provided telephonically or electronically.

Management of CBHI Service Provision

The Contractor shall:

Ensure that Network Providers of CBHI Services provide each such service in accordance with all EOHHS-approved CBHI Services performance specifications and CBHI Services Medical Necessity criteria.

Ensure that appropriate members of Providers' staffs participate in CBHI training, coaching, and mentoring as approved by EOHHS for CBHI training. The Contractor shall ensure that such members of Providers' staffs complete CBHI training, and utilize their new skills in service delivery. If the Provider is not participating in CBHI training, the Contractor shall engage in Provider Network management activities to increase training.

Develop operational manuals for selected CBHI services, including but not limited to Mobile Crisis Intervention.

Perform quality assurance and training activities for CBHI services as directed by EOHHS. These activities shall include providers within the networks of MassHealth Managed Care entities who provide CBHI Services.

Work collaboratively with all MassHealth payers to manage the network of all CBHI Service providers, including the Community Service Agencies (CSAs) that provide ICC and Family Support and Training, as well as the providers of In-Home Therapy, In-Home Behavioral Services and Therapeutic Mentoring, by:

Coordinating regional and statewide meetings for all CBHI service types that include all MassHealth payers, at a frequency agreed to annually by EOHHS. Contractor is responsible for coordination and administrative costs associated with such meetings; and

Coordinating with all MassHealth payers to provide joint technical assistance and network management to specific CBHI providers as necessary to address quality improvement and ensure full program implementation.

Manage the existing Community Service Agencies that are contracted to deliver ICC and FS and T services. Any changes to the CSA network must be approved in advance by EOHHS.

Maintain, revising as necessary and submitting to EOHHS for approval whenever revised, the Intensive Care Coordination and Family Support and Training Operations Manual (ICC Ops Manual). The Contractor shall ensure that the ICC Ops Manual conforms to the EOHHS-approved performance specifications for ICC and FS and T. The Contractor shall distribute the EOHHS-approved ICC Ops Manual to all CSAs in the Network.

Ensure that CSAs provide ICC and FS and T services according to both the EOHHS-approved performance specifications and the EOHHS-approved ICC Ops Manual. In the event that there are discrepancies between the two documents, the performance specifications shall control and the Contractor shall notify EOHHS of any discrepancies and submit a correction for EOHHS approval.

Assign a point of contact for management for each CSA and identify such individual to EOHHS prior to the Service Start Date. Responsibilities shall include, but are not limited to, providing technical assistance to CSAs to answer questions regarding authorization of services and assisting CSAs in facilitating and ensuring that Network Providers engaged in a Covered Individual's treatment participate in ICC Individual Care Plan meetings.

Require CSAs to track and report monthly to the Contractor on ICCs and referrals to ICC services according to the template provided in the ICC Ops Manual. The reported data shall include de-identified information for all MassHealth Members using these services, regardless of which plan they are in.

Require CSAs to provide the Contractor with EOHHS-required data for a particular month in sufficient time to submit such reports to EOHHS by the 30th of the following month (or by the next business day after the 30th if the 30th falls on a weekend day).

Ensure that each CSA coordinates and maintains a local Systems of Care committee to support the CSA's efforts to establish and sustain collaborative partnerships among families and community stakeholders in its geographic area. The Contractor shall assign a staff person to oversee the local Systems of Care committees; the staff person's responsibilities shall include but are not limited to:

attending meetings of the Systems of Care committees on a quarterly basis;

monitoring System of Care committees' activities and issues on a monthly basis through review of meeting minutes; and

conducting network management meetings with the CSAs.

In collaboration with, and as further directed by EOHHS, develop a plan to ensure that the quality of ICC and FS and T services is measured using tools that are consistent with national Wraparound standards, such as the

Wraparound Fidelity Index tool and the Team Observation measure ("fidelity tools"), and provide CSAs with such fidelity tools at no cost to the CSAs. In addition, use tools such as the MA DRM (Document Review Measure) to review medical files in both ICC and IHT.

Generate a random sample of 50 youth with Serious Emotional Disturbance, who, as indicated in their CANS assessment, are currently receiving outpatient therapy services and, for the previous 12 months have not received either Intensive Care Coordination or In-Home Therapy. For each of these 50 youth, the Contractor shall review the clinical record and interview the youth's therapist and caregiver, to obtain answers to the questions EOHHS has provided to the Contractor. The Contractor shall report the results of this sample survey to EOHHS by June 14, 2013.

In collaboration with and as further directed by EOHHS, develop a process to monitor the quality of services using tools such as the MA DRM or another tool approved by EOHHS to evaluate the adequacy of medical record keeping for both ICC and In-Home Therapy Services (IHT). The Contractor shall apply the approved quality assessing tool at least annually on a mix of ICC and IHT services provided across all of the Contractor's regions. The Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Covered Individuals who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 25 Covered Individuals medical files per region per Contract Year.

CBHI Access Reporting

The Contractor shall ensure that the web-based Behavioral Health Service Access System or the Contractor's equivalent system, as referenced in **Section 3.4.A.12** above, is updated at least once a week for CBHI Services (ICC, IHBS, TM and IHT) to show access and availability.

CBHI Service reporting must be available to the public on the system.

CBHI access and availability reports must be reported monthly from this system.

Special Service Initiatives

During the term of the Contract the Contractor shall propose for EOHHS's review and approval special new services and programs for Covered Individuals for which the Contractor may need to adapt its Provider Network. The Contractor shall perform a cost-benefit analysis for any new service it proposes to develop, as directed by EOHHS, including whether the proposed services would have an impact on Base PMPM Capitation Rates or the Administrative Component of the MassHealth Capitation Payment.

The Contractor shall implement new special services and programs as approved by EOHHS.

Network Administration

Network Provider Database

The Contractor shall maintain:

An up-to-date database that contains, at a minimum, the following information on Network Providers:

Network Provider name;

contracted services;

site address(es) (street address, town, ZIP code, region of the state);

site telephone numbers;

site hours of operation;

Emergency/after-hours provisions;

professional qualifications and licensing;

areas of specialty relating to Behavioral Health conditions and MassHealth populations listed in **Sections 3.1.B.6** and **3.1.B.7** above;

cultural and linguistic capabilities;

malpractice insurance coverage and malpractice history;

credentialing status;

status as women- or minority-owned or -controlled organization; and

Provider e-mail address.

A list of Network Providers, sorted by type of service and by Network Providers' capability to communicate with Covered Individuals in their primary languages. This list shall be available to the Contractor's clinical staff at all times, and available to Network Providers, PCC Plan Enrollees, EOHHS, DMH and other interested parties upon their request and at no charge.

Network Provider Policy and Procedure Manual

The Contractor shall:

Prior to the Service Start Date, develop and submit to EOHHS for approval a Provider policy and procedure manual, and, following EOHHS approval, publish the manual on Contractor's website and electronically distribute a hyperlink to the manual to all Network Providers. At a Network Provider's

request, also electronically distribute the manual to the Providers. The manual shall include, at a minimum, information on:

The Contract, the Contractor, and program priorities;

How to verify a Covered Individual's eligibility for MassHealth Behavioral Health Covered Services;

Network Provider Credentialing Criteria;

Provider Network management;

Procedures for service authorization, concurrent review, extensions of lengths of stay, and retrospective reviews for all BH Covered Services;

Clinical Criteria for admission, continued stay, and discharge for each BH Covered Service;

Administrative and billing instructions, including a list of procedure codes, units and payment rates;

How to appeal payment and service denial decisions;

Reporting requirements for Serious Reportable Events and Reportable Adverse Incidents; and

Performance specifications for each Behavioral Health Covered Service.

As necessary, modify or supplement the policy and procedure manual by distributing periodic notices to Network Providers;

Review the manual at least biannually and amend it, if necessary, in consultation with EOHHS; and

Redistribute the amended portions of the manual to Network Providers.

Performance Specifications

The Contractor shall:

Require all Network Providers to accept the Contractor's performance specifications that have been approved by EOHHS;

Develop and maintain performance specifications for Network Providers and develop performance specifications for new BH Covered Services; and

At least annually, review and update as necessary the performance specifications including any new performance specifications that have been developed, and submit any proposed changes to EOHHS for prior review and approval.

Network Provider Protocols

The Contractor shall develop, maintain and utilize EOHHS-approved Network Provider protocols. The protocols must address the following:

How the Contractor intends to ensure, for a particular Covered Individual's needs, that a qualified and clinically appropriate Network or non-Network Provider:

is available to provide the particular BH Covered Service;

is accessible within the access standards required by the Contract, taking into account the availability of public transportation;

is accessible to individuals with physical disabilities, if appropriate (see **Sections 3.1.B.7** and **3.1.G** and **H**); and

has the ability, either directly or through a skilled medical interpreter, to communicate with the Covered Individual in his/her primary language (see **Sections 3.1.B.7** and **3.1.G** and **H**).

How the Contractor intends to facilitate communication between Network Providers and the Contractor, and between Network Providers and PCCs, in a manner that engages the Providers and overcomes barriers to communication.

The Contractor shall require Network Providers to submit to the Contractor a written report of all Reportable Adverse Incidents, using the form found in **Appendix F** or other similar form acceptable to EOHHS, according to the following guidelines:

Network Providers of 24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents involving a Covered Individual.

Network Providers of non-24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents that involve the death of a Covered Individual.

The Contractor shall require Network Providers to coordinate MassHealth Covered Services with the Covered Individual's care manager where the Covered Individuals are receiving Care Management services through the Contractor and/or the case manager when the Covered Individual is receiving case management through a state agency (e.g., DMH, DCF, DDS, DYS).

The Contractor shall require Network Providers to comply with DPH's regulations barring payment for services related to a Serious Reportable Event.

The Contractor shall require Network Providers to comply with all of the following Massachusetts regulations and DMH policy memorandums:

DMH Policy Memorandum #96-3R of August 22, 1996, on informed consent, found at http://www.mass.gov/eohhs/docs/dmh/policy/policy-96-3r.pdf, or any successive policy or regulation;

DMH regulations on human rights and restraint & seclusion at 104 CMR 27 and 104 CMR 28, or any successive regulation; and

M.G.L. c. 123, § 23.

The Contractor shall require its Network Providers of Community-Based Acute Treatment Services and Transitional Care Units to comply with Department of Early Education and Care (DEEC) standards for the licensure or approval of residential programs serving Members under 18, as set forth in 102 CMR 3.00, et seq. For those CBAT and TCU Providers that are not located in a site licensed by DEEC, the Contractor shall ensure that these programs are located in a facility that is licensed by DMH and/or DPH.

The Contractor shall require its Network Providers to inform Covered Individuals of their rights under DMH regulations concerning human rights**.**

The Contractor shall comply with EOHHS protocols to ensure access to Behavioral Health Covered Services and tracking in the EOHHS Data Warehouse and MMIS systems by adhering to the following requirements:

Maintain a unique Network Provider identification number for each Network Provider, as described in **Section 9.3.A**.

Submit to EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department by the Service Start Date a list of all Network Providers who are both MassHealth Providers and Network Providers (dual Providers). The Contractor shall inform EOHHS's Enrollment Broker upon enrolling or disenrolling any dual Provider from its Provider Network.

Inform EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department immediately upon enrolling any Provider who is not also a MassHealth Provider in its Provider Network. Such notification shall include the following data elements:

Network Provider name, address and telephone number;

Legal entity's name, address and phone number of the practice (i.e., "doing business as," or d/b/a, name), if different from the above;

Network Provider or legal entity's tax identification number; and

Effective date of the Network Provider's enrollment in the Provider Network.

The Contractor shall submit to the Customer Services vendor all updates to the list or its data elements whenever they occur.

Network Provider Administrative Education and Training

The Contractor shall develop an education and training plan that provides appropriate information and learning sessions for Network Providers and their staff. Such education and training plan shall be submitted to EOHHS for approval and shall include, at a minimum:

A schedule for the development and release of educational materials;

A schedule for the development and timing of training sessions;

Regional training opportunities for Network Providers' clinical and administrative staff; and

Proposed education and training topics, including but not limited to:

new changes to policies and procedure prior to their implementation;

basics of MassHealth coverage and payment requirements; and

quality improvement efforts and the Network Provider's role, include linkages across Behavioral Health and physical health services.

Claims Handling

The Contractor shall:

Unless otherwise approved by MassHealth, operate from the Contractor's principal Massachusetts place of business a Claims review, processing and payment system for Network Providers that furnish BH Covered Services;

Pay all Clean Claims for all Behavioral Health Covered Services authorized by the Contractor and furnished to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only, within one month of receipt from Network Providers, unless the Contractor and Network Providers agree to an alternate payment schedule;

Prior to the Service Start Date, develop a procedure for denying Claims that includes a coding system for Claim denials and Claims that are pending, and incorporates the following policies:

Denial of reimbursement for Claims for any services that were not authorized by the Contractor, where service authorization is required;

Denial of reimbursement for Claims that are not submitted in compliance with the Contractor's administrative and billing submission requirements;

Denial of Claims for BH Covered Services provided to individuals who are neither Covered Individuals nor Uninsured Individuals or persons covered by Medicare only who have received ESP Services;

Denial of Claims for Covered Individuals when such services are paid for by Medicare or other health insurance; and

Where a Claim review results in a denial, preparation and mailing of the Claim denial to the Network Provider within two months of receipt of the Claim;

Develop an Internal Appeal process for reviewing and resolving denied Claims and payment disputes, and implement it as of the Service Start Date. The Internal Appeal process shall include the following:

Written policies and procedures for the filing, receipt, prompt resolution and documentation of all Internal Appeals brought by a Network Provider;

A means for assessing and categorizing the denied Claims and payment disputes;

Time frames for resolution and response by the Contractor; and

A definitive statement that Network Providers do not have a right to review or appeal a denied Claim directly to EOHHS.

Retrospective Utilization and Review of Network Providers

The Contractor shall:

Develop a description of its approach to retrospective utilization review of Network Providers and submit it to EOHHS for approval no later than six months after the Service Start Date. Such approach shall include a system to identify utilization patterns of all Network Providers by significant data elements and established outlier criteria for both Inpatient and Outpatient Services.

Conduct retrospective and peer reviews of a sample of Network Providers to ensure that the services furnished by Network Providers were provided to Covered Individuals, were appropriate and Medically Necessary, and were authorized and billed in accordance with the Contractor's requirements.

Program Integrity, Fraud and Abuse Prevention, Detection and Reporting

Program Integrity Requirements – Internal Controls

In accordance with 42 CFR 438.608, the Contractor shall have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against fraud and abuse. The arrangements or procedures must include the following:

Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards;

The designation of a compliance officer and a compliance committee that is accountable to senior management;

Effective training and education for the compliance officer and the Contractor's employees;

Effective lines of communication between the compliance officer and the Contractor's employees;

Enforcement of standards through well-publicized disciplinary guidelines;

Provision for internal monitoring and auditing; and

Provision for prompt response to detected offenses, and for development of corrective action initiatives.

Provider and Covered Individual Fraud and Abuse Prevention, Detection and Reporting

The Contractor shall:

Develop and maintain a comprehensive internal fraud and abuse program to detect and prevent fraud and abuse by Network Providers and Covered Individuals;

In accordance with M.G.L. c. 12, § 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution;

Upon a complaint of fraud or abuse from any source or upon identifying any questionable practices, conduct a preliminary review to determine whether, in the Contractor's judgment, there is sufficient reason to believe that the Provider or the Covered Individual has engaged in fraud or abuse, and where sufficient reason exists, report the matter in writing to EOHHS within 10 days;

If the Contractor's preliminary review or any further review or audit of a Network Provider suspected of fraud involves contacting the Network Provider in question, first notify EOHHS and receive its approval prior to initiating such contact;

Make diligent efforts to recover improper payments or funds misspent due to fraudulent or abusive actions by the organization or its subcontractors;

Require Network Providers to implement corrective actions or terminate Provider Agreements, as appropriate;

Submit ad hoc and semiannual written reports on its fraud and abuse activities according to the format specified by EOHHS. Said reports shall include the items outlined in **Appendix E-1**;

Have the CEO, CFO, or compliance officer certify in writing on an annual basis to EOHHS, using the template in **Appendix E-3**, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with **Section 3.7.H** of this Contract and has not been made aware of any instances of fraud and abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS;

Notify EOHHS in writing within 10 calendar days if it or, where applicable, any of its subcontractors receive or identify any information that gives them reason to suspect that a MassHealth Provider or Covered Individual has engaged in fraud as defined under 42 CFR 455.2. In the event of suspected fraud, no further contact shall be initiated with the Provider or Covered Individual on that specific matter without EOHHS's approval;

Cooperate fully and, where applicable, require its subcontractors to cooperate fully with the Office of the Attorney General's Medicaid Fraud Division (MFD) and the Office of the State Auditor's Bureau of Special Investigations (BSI). Such cooperation shall include but not be limited to:

providing, at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their responsibilities regarding Medicaid fraud and abuse;

maintaining the confidentiality of any such investigations; and

making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.

Notify EOHHS of all Provider overpayments above $75,000 or any voluntary Network Provider disclosures resulting in the receipt of overpayments in excess of $75,000, even if there is no suspicion of fraudulent activity.

Employee Education about False Claims Laws

The Contractor shall comply with all federal requirements for employee education about false claims laws under 42 U.S.C. § 1396a(a)(68) if the Contractor received or made Medicaid payments in the amount of at least $5 million during the prior federal fiscal year.

If the Contractor is subject to such federal requirements, the Contractor must:

on or before September 30 of each year, or such other date as specified by EOHHS, provide written certification, in a

form acceptable to EOHHS and signed under the pains and penalties of perjury, of compliance with such federal requirements;

make available to EOHHS, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. § 1396a(a)(68), any employee handbook, and such other information as EOHHS may deem necessary to determine compliance; and

initiate such corrective action as EOHHS deems appropriate to comply with such federal requirements.

Failure to comply with this section may result in intermediate sanctions in accordance with **Section 13.18**.

Fraud and Abuse Prevention Coordinator

The Contractor shall designate a fraud and abuse prevention coordinator, who may be the Contractor's compliance officer, and who is responsible for the following:

Assessing and strengthening internal controls to ensure Claims are submitted and payments properly made;

Developing and implementing an automated reporting protocol within the Claims processing system to identify billing patterns that may suggest Network Provider and/or Covered Individual fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

Conducting regular reviews and audits of operations to guard against fraud and abuse;

Receiving all referrals from employees, Covered Individuals or Network Providers involving cases of suspected fraud and abuse and developing protocols to triage all referrals involving suspected fraud and abuse;

Educating employees, Network Providers and Covered Individuals about fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per M.G.L. c. 12, § 5J; and

Establishing mechanisms to receive, process, and effectively respond to complaints of suspected fraud and abuse from employees, Providers and Covered Individuals and report such information to EOHHS.

Reporting

The Contractor shall submit to EOHHS all required reports related to Network Providers and Provider Network management, as described in this **Section 3** or in **Appendix E-1**, in

accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

CLINICAL SERVICE AND UTILIZATION MANAGEMENT

Administrative Requirements

Overview

The Contractor shall:

As of the Service Start Date, perform all clinical and Utilization Management (UM) functions and be responsible for the clinical management of Network Providers as described in this Contract.

Develop the Clinical Criteria to govern the authorization of services provided under the Contract. As part of the development process, the Contractor shall consult with experts who are familiar with standards and practices of mental health and substance abuse treatment for adults and children and adolescents in Massachusetts. The Contractor shall:

Submit the proposed Clinical Criteria to EOHHS for review and approval; and

Annually review, and update as necessary, the Clinical Criteria and any other clinical protocols that have been developed, and submit any proposed changes to EOHHS for prior review and approval.

Develop and maintain UM policies and procedures, including but not limited to policies and procedures for service authorizations that are consistent with the EOHHS-approved Clinical Criteria the Contractor has developed, and with the requirements set forth in **Section 4.2**. The Contractor shall:

Initially, submit the UM policies and procedures to EOHHS for approval at least one month prior to the Service Start Date.

Annually review, and update as necessary, the UM policies and procedures and submit any proposed changes to EOHHS for prior review and approval. The UM policies and procedures shall be conveyed through staff training and supervision, and shall:

ensure that Covered Individuals receive the care that is Medically Necessary; and

place emphasis on ensuring that BH Covered Services are not over-utilized or provided without a determination of Medical Necessity.

Staffing

The Contractor shall employ a multidisciplinary clinical staff at staffing levels that ensure an adequate ratio of staff to Covered Individuals to perform the clinical, UM and Care Management Program functions of the Contract, including authorizing and coordinating services.

The Contractor shall ensure that the Chief Medical Officer or an Associate Medical Director is available 24 hours per day, seven days a week, for decision-making and consultation with the Contractor's clinical staff and Network Providers.

The Contractor shall make best efforts to ensure that the clinical staff described herein have never had any disciplinary or other type of sanction action taken against him or her by the relevant professional licensing or oversight board, or the Medicare or Medicaid program. The Contractor shall require its clinical staff to disclose to the Contractor any such action taken against current Contractor staff, and the Contractor shall inform EOHHS within five days of becoming aware of any such action.

Staff must include:

A full-time Chief Medical Officer who is designated as key personnel. The Chief Medical Officer shall: be board-certified in psychiatry and/or internal medicine; be in compliance with all professional licensing requirement; and have at least two years of experience in managed BH care, peer review, or both.

At least two full-time equivalent (FTE) Associate Medical Directors, each of whom shall be physicians, and:

One shall be board-certified or board-eligible in child and adolescent psychiatry.

One shall be board-certified or board-eligible in internal medicine, with experience in integration of care across medical and Behavioral Health Providers and shall be responsible for the oversight of the Care Management Program described in **Section 6.2**.

One shall be responsible for the oversight of the Quality Management program described in **Section 8**.

If the full-time Chief Medical Officer is not a board-certified adult psychiatrist, then an additional full-time equivalent Associate Medical Director must be a board-certified adult psychiatrist.

Supervisory clinical staff with expertise in medical or Behavioral Health care who represent nursing, social work, psychology, substance abuse, counseling or other

BH fields, possess sufficient educational background and experience, have all applicable professional licenses, have experience in managed care, UM, and QM.

Supervisory staff that include subject matter experts in Severe and Persistent Mental Illness, Severe Emotional Disturbances in children and adolescents, intellectual disabilities, substance abuse treatment, and treatment of persons with Dual Diagnosis.

Staff clinicians at the master's level or bachelor's level. Bachelor's-level staff shall perform tasks not pertaining to Medical Necessity determination.

Training and Supervision

The Contractor shall ensure that all staff are appropriately licensed at hiring and during the tenure of employment. In addition, the Contractor shall:

Ensure that staff clinicians receive weekly group or individual clinical supervision to ensure standardization and quality.

Ensure that clinical staff obtain the training (i.e., CEUs, CMUs) needed to maintain their professional licensing.

Ensure that clinical staff are trained on Clinical Criteria, Utilization Management standards and on Member rights for Internal Appeals and Grievances.

Service Authorization, Utilization Review, Clinical Service Coordination and Clinical Referral

Policies and Procedures for Service Authorization

Standards for Clinicians

The Contractor shall ensure the following standards for clinicians who authorize services, unless otherwise approved by EOHHS:

The clinician(s) coordinating services and making service authorization decisions must have training and experience in the specific area of service for which they are coordinating and authorizing services.

The clinician(s) coordinating and authorizing adult mental health services must have experience and training in adult mental health services.

The clinician(s) coordinating and authorizing child and adolescent mental health and substance abuse services must have experience and training in child and adolescent mental health and substance abuse services, including services for Children in the Care and/or Custody of the Commonwealth and children who have experienced trauma.

The clinician(s) coordinating and authorizing adult substance abuse services must have experience and training in adult substance abuse services.

The clinician(s) coordinating and authorizing services for a PCC Plan Enrollee with a coexisting medical and BH diagnosis must be a registered nurse, psychiatrist, or other licensed clinician with experience and training in services with a coexisting medical and BH diagnosis.

In the event a clinician with experience in the specific area of service is unavailable to authorize a service, appropriate clinical consultation must be provided.

Service Authorization Procedure

The Contractor shall implement, as of the Service Start Date, its written policies and procedures for processing of requests for initial and continuing authorizations of services which, among other things:

Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a board-certified or board-eligible psychiatrist or health care professional who has appropriate clinical expertise treating the condition or disease at issue, except as provided in subsection **2.b**;

In cases of denials of services for psychological testing, require that the denials be rendered by a qualified psychologist;

Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

Consult with the requesting Network Provider when appropriate;

Make authorization decisions and provide notice as follows and as further specified in **Section 7.6**.

For standard authorization decisions, make a decision and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the Covered Individual's health condition requires and within the following timeframes:

For Outpatient Services, Outpatient Day Services, and non-24-hour Diversionary Services, the Contractor shall make a decision no later than 14 calendar days following receipt of the request, and shall mail a written notice to both the Covered Individuals and the Network Provider on the next business day after the decision is made; and

For Inpatient Services and 24-hour Diversionary Services, the Contractor shall make a decision within 24 hours of the request, notify the Network Provider orally within 24 hours, and notify both the Covered Individual and the Network Provider in writing within three days;

For expedited service authorization decisions, where the Network Provider indicates or the Contractor determines that following the standard timeframe in subsection **2.e.1)** could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make a decision and provide notice as follows:

The Contractor shall make a decision as expeditiously as the Covered Individual's health condition requires and within three business days after receipt of the request for service, with a possible extension not to exceed an additional 14 calendar days. Such extension shall be allowed only if:

the Covered Individual or the Network Provider requests an extension; or

the Contractor can justify (to EOHHS upon request) that (a) the extension is in the Covered Individual's interest, and (b) there is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and such outstanding information is reasonably expected to be received within 14 calendar days.

The Contractor shall notify the Network Provider orally and notify both the Covered Individual and the Network Provider in writing of any denial or decision to authorize services in an amount, duration, or scope that is less than requested on the day that the decision is made.

In accordance with 42 CFR 438.6(h) and 422.208, ensure that compensation to individuals or entities that conduct Utilization Management activities for the Contractor are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Individual.

Require the Contractor to conduct monthly reviews of a random sample of no fewer than 50 Covered Individuals per month to ensure that such Covered Individuals received the services for which Network Providers billed with respect to such Covered Individuals.

Specify that prior authorization shall not be required for Inpatient Substance Use Disorder Services (Level IV), Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7), and Clinical Support Services for Substance Use Disorders (Level III.5), as defined in Appendix A;

Require that Providers providing Clinical Support Services for Substance Use Disorders (Level III.5) shall provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee; and

If utilization management review activities are performed for Clinical Support Services for Substance Use Disorders (Level III.5), such activities may be performed no earlier than day 7 of the provision of such services.

Notwithstanding any other provision of this Contract, the Contractor shall not authorize services or treatment plans for services to be rendered after the termination of this Contract without EOHHS's prior review and approval, or unless otherwise directed by EOHHS.

Clinical Referral and Service Authorization Functions

Clinical Referrals Function

In order to assist Providers and Covered Individuals in identifying Network Providers who can provide BH Covered Services in accordance with this Contract, the Contractor shall operate and maintain a toll-free Clinical Referral Line that is staffed 24 hours a day, seven days a week by, at a minimum, bachelor's-level staff who are trained and knowledgeable about Contractor referral resources and who can make appropriate referral suggestions.

Service Authorization Function

In order to authorize delivery of Behavioral Health Covered Services, if appropriate, and to assist Providers and Covered Individuals in identifying Network Providers who can provide Covered Services in accordance with this Contract, the Contractor shall operate and maintain a toll-free Service Authorization Line that is staffed 24 hours a day, seven days a week by, at a minimum, master's-level staff as described in **Section 4.1.B.4.c**. Such clinical staff shall have access to Covered Individuals' clinical and service authorization information.

The Contractor shall ensure that supervisory staff is available to assist staff clinicians with handling calls to the Service Authorization Line.

The Contractor shall propose for EOHHS review and approval a plan to adopt an alternative to the Service Authorization Line and/or additional method for Network Providers to request and receive authorization for services.

The Contractor shall coordinate service authorization functions with the Care Management Program described in **Section 6.2**, as appropriate.

Service Authorization for Specific BH Covered Services

Inpatient Service Authorization

The Contractor shall develop Inpatient Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

A plan and system in place to direct Covered Individuals to the least intensive clinically appropriate service;

A system for ensuring that, to the extent permitted by law, authorizations for inpatient admissions occur after an ESP has conducted a crisis assessment and determined that the admission of the Covered Individual is Medically Necessary;

Processes to ensure placement for Covered Individuals who require Behavioral Health Inpatient Services when no inpatient beds are available;

A system for authorizing and assigning an initial length of stay for all admissions, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 4.2.A.2.e**;

A system for ensuring that Inpatient Services are authorized for 24 hours for all Covered Individuals ordered hospitalized by a judge pursuant to M.G.L. c. 123 § 12(e); and that Inpatient Services for such individuals are authorized for more than 24 hours only if the Contractor determines that such services are Medically Necessary;

A system of concurrent review for Inpatient Services to monitor the Medical Necessity of the need for continued stay and achievement of Behavioral Health Inpatient treatment goals;

A system for addressing Discharge Planning during initial authorization and concurrent review;

A system for conducting retrospective reviews of the medical records of selected inpatient authorizations, to assess the Medical Necessity, clinical appropriateness, and appropriateness of the Level of Care and duration of the stay; and

A system for ensuring that the Inpatient Services Network Provider asks for the Covered Individual's consent to notify the Covered Individual's PCC that the Covered Individual has been hospitalized.

24-Hour Diversionary Service Authorization

The Contractor shall develop Diversionary Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

A system that operates 24 hours a day, seven days a week, for authorizing admissions of Covered Individuals to 24-hour Diversionary Services, utilizing the Contractor's Clinical and Medical Necessity Criteria;

A system for making clinically appropriate referrals for children and adolescents in need of Community-Based Acute Treatment Services for Children and Adolescents when such Providers have no available beds;

A system for authorizing and assigning an initial length of stay for all admissions to 24-hour Diversionary Services, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 4.2.A.2.e**;

A system for authorizing non-24-hour Diversionary Services based on Medical Necessity Criteria;

A system of concurrent review for 24-hour Diversionary Services to monitor justification and appropriateness of the length of stay, need for continued stay, and achievement of treatment goals;

A system for addressing Discharge Planning during initial authorization and concurrent review;

A system for ensuring that Network Providers of 24-hour Diversionary Services ask for the Covered Individual's consent to notify the Covered Individual's PCC that the Covered Individual has been admitted; and

A system for conducting retrospective reviews of the medical records of selected Diversionary Services cases, to assess the Medical Necessity, clinical appropriateness, and appropriateness of Level of Care and duration of the stay.

Outpatient Service Authorization

The Contractor shall develop Outpatient Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor

proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

A system that operates 24 hours a day, seven days a week;

A policy and system for automatically authorizing at least 12 outpatient sessions per Covered Individual per Contract Year;

A policy and system, secure from unauthorized access, for authorizing outpatient sessions beyond 12 sessions;

A policy and system for authorizing Outpatient Services and lengths of treatment based on the Contractor's Clinical Criteria;

A policy and system for generally informing Network Providers of the Contractor's protocols for approving Outpatient Services, such as including such protocols in the Provider Manual; and

A policy and system to ensure that the provision of outpatient BH Services is based on the individual clinical needs of each Covered Individual, and that the BH Covered Service(s) provided are the least intensive clinically appropriate service(s).

Assessment, Treatment Planning and Discharge Planning

Assessments

The Contractor shall:

Ensure that all Network Providers prepare an individualized written assessment for any Covered Individual entering treatment, regardless of treatment setting.

Ensure that assessments are conducted by Network Providers and include but are not limited to:

history of presenting problem;

chief complaints and symptoms;

past BH history;

past medical history, including but not limited to Primary Care, specialty care, treatment for chronic conditions, and use of prescription drugs;

the Covered Individual's family history, social history and linguistic and cultural background, with an assessment of the Covered Individual's identified supports in each of these domains;

for Children in the Care and/or Custody of the Commonwealth, history of placements outside the home;

current substance use;

mental status exam including assessment of suicide and violence risk;

previous medication trials, current medications and any allergies;

diagnosis, clinical formulation, rationale for treatment, and recommendations;

level of functioning;

the individual's strengths and, for children and adolescents, family strengths; and

name of PCC and other key Providers.

Ensure that when assessments are completed, a multidisciplinary treatment team has been assigned to each Covered Individual. The multidisciplinary treatment team shall, with consent from the Covered Individual, include the following Providers and community supports, as appropriate for the Covered Individual's clinical needs: the PCC, current community-based BH Network Providers, other specialists, state agency case managers and/or service providers, Peer Supports identified by the Covered Individual, and others recommended by a team member or requested by the Covered Individual. For children under 18, a parent or legal guardian must be an active participant in the team. The treatment team shall meet to review the assessment and initial treatment plan within the following time frames:

For Inpatient Services: within 24 hours of admission;

For Diversionary Services: within 48 hours of admission; and

For Outpatient Services, for clinics, group practices and solo practitioners, the timeline specified in DPH regulation 105 CMR 140.540.

Make best efforts to ensure that the assessments are conducted by Network Providers who have training and experience that match the Covered Individual's clinical needs based on the Covered Individual's presenting problem(s) and diagnosis.

Require the clinicians who provide Behavioral Health services described in **Section 3.5** to use the CANS Tool and the information gathered from its use to inform treatment planning and Discharge Planning when: providing initial Behavioral Health Clinical Assessments; as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations, and Community-Based Acute Treatment Services; and, at a minimum, every

90 days during treatment provided to Covered Individuals who are under age 21.

Treatment Planning

The Contractor shall ensure that its Network Providers:

Utilize the individualized written assessment, including the clinical formulation, to develop a treatment plan;

Develop initial treatment plans that are in writing, dated and signed, and include, at a minimum:

a description of all services needed during the course of treatment;

goals, expected outcomes and time frames for achieving the goals;

indication of the strengths of the individual and his/her family as identified in the assessment;

links to Primary Care and specialty care, especially when there is an active co-occurring medical condition;

when appropriate, the plan to involve a case manager from a state agency, such as DCF, DMH, DYS or DDS; and

treatment recommendations consistent with the service plan of the relevant state agency for Covered Individuals who are also DMH Clients, Children in the Care and/or Custody of the Commonwealth, or DDS clients.

Periodically review initial treatment plans and modify them as necessary;

Receive Covered Individual medical and pharmaceutical profiles on a regular basis and use these profiles as part of its periodic review of the Covered Individual's treatment plan;

Invite and encourage the following persons to participate in the development and modification of the Covered Individual's treatment plan, the treatment itself, and to attend all treatment plan meetings:

In the case of an individual over age 16 or an emancipated minor, the Covered Individual, the Covered Individual's family members, guardians, the PCC, Network Providers of BH Outpatient Services, key specialists and other identified supports, but only when the consent of the Covered Individual to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case the consent of the legal guardian is required.

In the case of an individual under age 16 who is not an emancipated minor, with the consent of a parent or guardian, the Covered Individual, if appropriate, family

members, the PCC, Network Providers of BH Outpatient Services, Family Partners, Care Coordinators, key specialists, and other identified supports.

For Covered Individuals who are also DMH Clients, DDS clients or Children in the Care and/or Custody of the Commonwealth, the designated staff from the relevant state agencies.

For Covered Individuals who are participating in Care Management through the Contract, the Contractor's assigned care manager.

Make best efforts to schedule treatment planning meetings concerning children and adolescents at a time when their family members or guardians are available;

Encourage Covered Individuals over the age of 18 to consent to the participation of guardians and family members in the treatment and treatment planning;

Assign a multidisciplinary treatment team to each Covered Individual within the following time frames:

for Inpatient Services: within 24 hours of admission;

for 24-hour Diversionary Services: within 24 hours of admission.

Discharge Planning

The Contractor shall:

Ensure that all Network Providers, especially Network Providers of Inpatient and Diversionary Services, upon admission of Covered Individuals:

assign appropriate designated staff who are knowledgeable about the continuum of coordinated BH and medical services, services and supports in the community, and Discharge Planning;

provide notice to the Covered Individual's PCC within one business day of the admission, include the PCC in current Discharge Planning efforts and schedule a follow-up appointment with the PCC for care, as appropriate;

coordinate and collaborate with the Contractor's care manager if the Covered Individual is participating in Care Management under the Contractor;

make best efforts to ensure a smooth transition to the next service, if any, or to the community;

document all efforts related to these activities, including the Covered Individual's active participation in his or her individualized Discharge Planning and, in the case of Covered Individuals under 18, their parent or legal guardian; and

Identify barriers to aftercare and develop strategies to assist Covered Individuals with aftercare services.

Develop, in collaboration with each Covered Individual, prior to the individual's discharge from any Inpatient BH Service or, if appropriate, any other BH Covered Service, a written, individualized person-centered, strength-based discharge plan for the next service or program, anticipating the individual's movement along a continuum of services, including availability of Wraparound services for children under 18 and their families;

Include in the discharge plan, at a minimum:

Identification of the individual's needs, including but not limited to:

housing;

finances;

medical care;

transportation;

family, employment, and educational concerns;

natural community and social supports; and

a Crisis Prevention Plan that follows the principles of recovery and resilience, and which may be a component of a Wellness, Recovery Action Plan (WRAP) model for adults and the Risk, Management, Safety Plan for children and their families.

A list of the services and supports that are recommended post-discharge;

Identified Providers, PCCs and other community resources available to deliver each recommended service;

A list of prescribed medication, dosages and possible side effects; and

Treatment recommendations consistent with the service plan of the relevant state agency for Covered Individuals who are also DMH Clients, Children in the Care and/or Custody of the Commonwealth, or DDS clients.

Invite and encourage the following persons to participate in Discharge Planning meetings:

In the case of an individual over age 16 or an emancipated minor, the Covered Individual, the Covered Individual's family members, guardians, PCC, Network Providers of

BH Outpatient Services, key specialists, and other identified supports, but only when the consent of the individual to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case consent of the legal guardian is required;

In the case of an individual under age 16 who is not an emancipated minor, with the consent of a parent or guardian, the Covered Individual, if appropriate, family members, PCC, Network Providers of BH Outpatient Services, key specialists and other identified supports;

For Covered Individuals who are also DMH Clients, Children in the Care and/or Custody of the Commonwealth, or DDS clients, designated staff from the relevant state agencies; and

For Covered Individuals receiving Care Management services through the Contractor, the Contractor's assigned care manager.

Schedule Discharge Planning meetings concerning children and adolescents at a time when their family members or guardians are available;

Develop linkages and policies that create a smooth, clinically sound transition of a Covered Individual's care from one service setting or BH Covered Service to the next, including transition to services provided by state agencies;

Assist Covered Individuals in obtaining post-discharge appointments as follows: within seven calendar days of discharge for aftercare services, which may include Outpatient Services as well as a broader range of BH Covered Services, including Non-24-Hour Diversionary Services such as partial hospital programs, if necessary; and within 14 calendar days of discharge for Medication Monitoring, if necessary;

Require the treatment team staff responsible for implementing the individual's discharge plan to document the discharge plan in the medical record;

Ensure that Network Providers of 24-hour Levels of Care furnish, with appropriate consent, a written discharge instructions to the Covered Individual, parents, guardians, residential providers, PCCs, and relevant state agencies or Contractor care managers at the time of the individual's discharge, to include, without limitation:

A list of prescribed medications and information about any potential medication side effects;

aftercare appointments;

recommended behavior management techniques when applicable; and

a Crisis Prevention Plan, including the toll-free phone number of the Member's local ESP.

Ensure that Network Providers of inpatient mental health, ICBAT and CBAT Providers furnish, with appropriate consent, a written discharge summary to the Covered Individual, parents, guardians, PCCs, Contractor care managers, and the Member's current Behavioral Health Providers within two weeks of discharge, to include a summary of:

the course of treatment;

the Member's progress;

the treatment interventions and behavior management techniques that were effective in supporting the Member's progress;

medications prescribed; and

treatment recommendations.

Ensure that the discharge plans for Covered Individuals who are DMH Clients are coordinated with the DMH Area or Site Office.

Additional Discharge Planning Requirements for Homeless Enrollees

The Contractor shall:

Strongly discourage Network Providers from discharging Homeless Enrollees to shelters;

Ensure that all Network Providers provide comprehensive Discharge Planning for Homeless Enrollees, and that Network Providers exhaust all potential avenues to secure placement or housing resources, with assistance from the Contractor;

Ensure that, within two business days of admission, all Network Providers complete and forward to DMH a DMH Service Authorization packet for Homeless Enrollees who appear to meet DMH clinical criteria for service eligibility;

Identify community resources for the Homeless and ensure that Network Providers are aware of and utilize all such resources to assist with Discharge Planning for Homeless Enrollees;

Collaborate with DMH to ensure that Network Providers are aware of and utilize all available DMH resources to assist with Discharge Planning for Homeless Enrollees; and

Maintain and periodically update website links to Homeless services resources on the Contractor's website to assist Network Providers with Discharge Planning for Homeless Enrollees.

Pharmacy Support Services

Overview

The MassHealth Pharmacy Program is the Pharmacy Benefit Manager (PBM) for the PCC Plan Enrollees and other Covered Individuals served under this Contract.

The Contractor shall:

Support the initiatives of the MassHealth Pharmacy Program, as directed by EOHHS.

Establish and maintain the capability to receive and analyze Claims data received from the EOHHS Data Warehouse for all Covered Services, including pharmacy utilization data for all Covered Individuals.

Establish and maintain the capacity for the Contractor's pharmacy director to create and submit reports regarding Provider prescribing patterns, and Covered Individuals' pharmacy claims and utilization patterns to Providers and to EOHHS, on a case-by-case ad hoc, non-production basis (i.e., reports manually produced by the Contractor's pharmacy director.).

The Contractor's pharmacy staff shall use these reports for Care Management and reconciliation activities, including but not limited to providing current information on pharmacy utilization to ICMP and MBHP staffs and upon request to Network Providers.

The Contractor's pharmacy director shall report quarterly to MassHealth on the pharmacy-related activities the Contractor has performed in support of this Contract. This report shall include but not be limited to the following categories of activities:

1) A summary report of the frequency of the pharmacists' interactions with care managers to support Covered Individuals in the ICMP and ECC programs;
2) A summary report of the number of members in each Pharmacy Program initiatives that DUR or OCA have referred to the Contractor's care management program and the results of referral;
3) The frequency and rationale for specific queries from Covered Individuals for other projects; and
4) Educational supports to:
    a) The ICMP program;
    b) Network Providers and PCCs;
    c) Pediatric Behavioral Health Medication Initiative (PBHMI);
    d) The inpatient medication reconciliation project;
    e) The controlled substances management program; and
    f) The PharmaConnect™ project or other pharmacy clinical care alert system as directed by EOHHS.

Ensure that sufficient pharmacist and/or clinical staff with an understanding of medication(s) as it relates to the project are available to fulfill the pharmacy requirements of the Contract.

a. Prior to July 20, 2014, provide to EOHHS for approval a staffing plan that ensures the integrity of pharmacy deliverables.

b. Continually evaluate staffing needs and provide to EOHHS for approval prior to the beginning of each Contract Year a staffing plan that ensures the clinical integrity of the pharmacy deliverables.

c. The Contractor's pharmacy director, as identified to EOHHS, shall have access to pharmacy data through POPS and the POPS data query tool known as "Business Objects" to support these efforts. If the Contractor supplies a level of clinical oversight for the use of the data that is approved by MassHealth, MassHealth may consider granting additional Contractor staff access to this tool on a case-by-case basis

Coordinate pharmacy support activities, as directed by EOHHS with DMH, and EOHHS's Drug Utilization Review (DUR) and Pharmacy Online Processing System (POPS) vendors.

For the purposes of this section the Contractor shall provide Member-level information described herein only to Providers who have a record of treating the Member, or otherwise as directed by MassHealth and consistent with prevailing laws and regulations.

Pharmacy Initiatives

The Contractor shall support and collaborate with MassHealth on pharmacy activities and efforts, including but not limited to:

Ensuring that Network Providers have access to the most current MassHealth Drug List, and that Network Providers prescribe pharmaceuticals in accordance with the policies and instructions provided by EOHHS and reflected in the MassHealth Drug List, and other MassHealth publications.

Using Covered Individuals' drug utilization data obtained from EOHHS to inform and guide prescribing activity. As part of this effort, the Contractor shall:

Work to improve collaboration by prescribers, thereby reducing conflicting or duplicate prescribing; and

Assist Care Managers in finding and implementing ways to improve Enrollees' compliance with prescribed medication regimens.

Providing reports to PCCs, other PCC Plan Providers, and Network Providers on the patterns of prescription utilization by Covered Individuals, in an effort to increase collaboration across providers and reduce inappropriate prescribing patterns.

Whenever a Covered Individual is admitted to a BH inpatient hospital, reviewing his or her complete medication regimen to ensure optimum quality of care at the time of admission, during hospitalization, at discharge and through his or her transition to the community, as more particularly set forth in this **Section 4.4.B.4**.

The goals of this activity are to:

Encourage the use of drugs that will not require prior authorization if it is reasonably expected that the Covered Individual will continue to use the drug after discharge;

Improve consistency in prescribed medications for Covered Individuals;

Reduce disruptions in the Covered Individual's medication regimen; and

Reduce incidence of harmful drug-to-drug interactions and poly-psychopharmacy.

Medication Reconciliation Project:

1) The Contractor shall send medication history upon a Covered Individual's admission to any appropriate Contractor's BH Network inpatient hospitals and psychiatric units at general hospitals utilizing the Multiyear Work plan developed in Contract Year Three in the newly created **Appendix K.**
2) Within Contract Year Four, complete a feasibility study of the Discharge component of the Medication Reconciliation Project to include the following:
    a. Report on the Contractor feasibility of methodologies to capture discharge medications and post-discharge prescribers, reconcile with post-discharge filling record, and communicate findings to discharge prescriber. Methodology shall include documentation of PA status.
    b. Report and utilize any lessons learned including from pilot, trial, or other evidence-based methodologies to decrease the rate of medication discrepancies pre- and post-discharge among the Contractor's BH Network inpatient hospitals and psychiatric units at general hospitals.
    c. At the end of quarter three (Q3) of Contract Year Four, provide to EOHHS at the MBHP/MassHealth Pharmacy Workgroup a progress report with recommendations to inform medication reconciliation activities for Year Five.
3) Utilize the Multiyear Work plan developed in Contract Year Three to reach deliverables in **subsections 1) and 2)** above.

Within three months after the implementation date of the protocol described in **Section 4.4.B.4.b**, the Contractor shall develop and submit for review a longitudinal (multi-year) work plan informed by the evaluation described in subsection b.4) above, to establish Medication Reconciliation protocols for all BH Network inpatient psychiatric hospitals and psychiatric units at acute general hospitals.

Medication Reconciliation shall include at minimum the following activities:

1) When the admitting facility notifies the Contractor that a Covered Individual has been admitted to a Network inpatient psychiatric hospital or a psychiatric unit at a non-psychiatric hospital, the Contractor shall provide the attending physician at the Network inpatient psychiatric hospitals and to the admitting physicians at psychiatric unit of a non-psychiatric hospital, all pharmaceutical claims and

utilization within 24 hours of admissions, including the prior authorization status of each.

Prior to the Covered Individual's discharge from the inpatient stay described in subsection 1) above, the Contractor shall obtain from the inpatient psychiatric hospitals details of the discharge medication regimen, and specifically identify medications newly prescribed during the hospitalization, and any that are discontinued. The Contractor shall identify all medications that require prior authorization on the Covered Individual's discharge plan and ensure that the hospital has included the prior authorization status of each medication.

Following the Covered Individual's discharge from inpatient care, the Contractor shall provide the Primary Care Provider and/or Behavioral Health Provider with ongoing Medication Reconciliation information to ensure that the patient follows the planned mediation regimen. This shall include but is not limited to analyzing post-discharge pharmacy claims to identify adherence to prescriptions regimens, including identification of delays in refilling prescriptions. The Contractor shall use this information to coordinate care for the Covered Individual, which may include enrollment in the Care Management Program.

Managing the prescribing of psychoactive medication to Covered Individuals under age 18, including:

a. Tracking psychopharmacology use and prescribing patterns;

b. Identifying target populations (e.g. age subsets) for proposed interventions;

c. If clinically indicated, the Contractor's Child/Adolescent Psychiatrist must make prescriber/doctor outreach calls and provide MassHealth a summary of these reviews/consultations. The Contractor and MassHealth shall coordinate prescriber/doctor outreach calls to avoid unnecessary duplication of outreach to the same prescriber for the same member and purpose.

d. If clinically indicated for Covered Individuals under 6 years old who are not receiving Behavioral Health services, the Contractor shall refer such members to ICMP for care management or care coordination.

Collaborating with and assisting EOHHS in the management of the MassHealth Controlled Substance Management Program (CSMP), which was developed to identify potential misuse or abuse of controlled substances. The Contractor's responsibilities shall include the following:

a. Identify every six months a cohort of Members meeting EOHHS criteria for CSMP through the following process:
   1) Analyze the pharmacy data to determine a list of potential members that meet criteria for pharmacy lock-in.

   2) Ensure that a clinician reviews the list to eliminate those members who appear to have a medically necessary reason(s) for their controlled substance use and produce final list of members to be included in the CSMP program.

b. Supply information to MassHealth Pharmacy Program and DUR Program as directed by EOHHS to assist in the enrollment into and disenrollment of members from the program.

c. Send Members identified in **Section 4.4.B.6.a** enrollment letters as approved by EOHHS.

d. Inform methadone providers when the Covered Individuals they treat also participate in CSMP.

e. Inform ICMP of any ICMP Members in CSMP.

f. Send PCC a letter approved by EOHHS if their patient is enrolled in CSMP and not using behavioral health or ICMP services according to criteria set by EOHHS.

g. Review MMIS every other month for any CSMP member who has changed his or her PCC and notify the new PCC that the Member is enrolled in CSMP. Such notification shall be by means of an EOHHS approved provider update letter that will include most recent 6 months of controlled substance medication prescription history.

h. Identify Members for disenrollment by EOHHS based on not meeting the criteria for enrollment during the past 4 quarter, 12 month review of controlled substance utilization.

i. Sending the names, addresses, Member ID and PCCs of each member to be released from pharmacy restriction to the DUR.

j. Send out discharge letter approved by EOHHS to Member's PCC upon discharge of Member from CSMP.

k. Evaluate the CSMP for effectiveness and report results to EOHHS in a timeframe agreed to by the parties. MBHP will track enrolled and dis-enrolled CSMP Members' prescription medication utilization to monitor the effectiveness of the program and to determine cost savings according to methodology jointly established by EOHHS and MBHP, changes in controlled substance prescription patterns, changes in ED use and utilization of behavioral health services.

l. Identify and engage Enrollees in CSMP who might need Behavioral Health services and medical care and help them access such services.

m. Work with MassHealth to determine how to implement a Prescriber Lock-in Program.

Support EOHHS pharmacy initiatives by promoting and communicating the adoption of MassHealth clinical policy recommendations to PCC Plan Providers and BH Network Providers.

Implementation of a technology system of alerts:

a. Based on an evaluation by EOHHS of ValueOptions PHarmaConnect™ technology system of alerts for Contract Year 3, EOHHS will decide whether to continue using the system, to use an alternative system, or to discontinue the system, and shall notify MBHP of such decision. Upon such notification from EOHHS, MBHP will either

continue current Phase 1, work with EOHHS to use an alternative system or discontinue the system, as applicable, and

b. If EOHHS decides to continue PharmaConnect™, MBHP will propose and implement upon EOHHS approval a work plan to expand PharmaConnect™ to other MassHealth prescribers and to include additional drug classes, including non-Behavioral Health drugs.

Propose additional pharmacy interventions focused on Covered Individuals. Such interventions shall include, at a minimum:

a. Identifying and mitigating duplication of, or conflict with, other pharmacy interventions by EOHHS or its Contractors;

b. Educating PCC Plan Providers and Network Providers on pharmaceuticals used for BH conditions, through PCC Plan Management Support Services (MSS) site visits, Network Provider site visits, or other methods, including publications;

c. Educating PCC Plan Providers and Network Providers regarding the need to coordinate and manage prescribed medication use for BH and medical conditions through an alert, brochure and/or newsletter; and

d. Collaboration with DCF, DYS and EOHHS to develop a system to monitor their clients' use of pharmaceuticals for BH conditions.

Implement other pharmacy interventions as approved by EOHHS in accordance with the time frames specified by EOHHS.

Work Group Participation

The Contractor shall assign its staff pharmacist to participate in all appropriate pharmacy work groups as determined necessary by the EOHHS, including but not limited to:

The Drug Utilization Review (DUR) Board as well as open DUR workgroups and committees;

The DMH drug advisory committee (known as the Psychopharmacology Experts Work Group);

The Children's psychopharmacology workgroup (known as the Psychoactive Medications in Children Working Group; and

Participation in any EOHHS pharmacy strategic planning process as requested or directed by EOHHS.

Massachusetts Child Psychiatry Access Project

The Massachusetts Child Psychiatry Access Project consists of children's mental health consultation teams throughout the state to help PCPs meet the needs of children with psychiatric problems. The primary goals of MCPAP are to improve access to treatment for children with psychiatric problems, and to promote productive relationships between primary care and child psychiatry and rational utilization of scarce resources.

The Contractor shall:

Establish a Massachusetts Child Psychiatric Access Project (MCPAP) Unit to manage the Massachusetts Child Psychiatric Access Project, and allocate sufficient medical leadership and program administration resources to assure that the goals of the program are met and quality is maintained.

Establish and maintain a network of MCPAP Providers to provide consultation to pediatric Primary Care Practitioners (PCPs), including Primary Care Clinicians (PCCs), treating pediatric Members who may need Behavioral Health services.

Recruit pediatric PCPs across the state who have not yet signed a MCPAP participation agreement.

Ensure that MCPAP services are available statewide through multiple teams of contracted and credentialed MCPAP Providers with each team responsible for specific geographic centers across the state. Each team shall include MCPAP Providers experienced in providing pediatric mental health and substance use disorder consultation.

Maintain a system to collect Encounter data; and utilize the Encounter data collected to evaluate and analyze the effectiveness of the MCPAP.

Contract with a sufficient number of MCPAP Providers in the geographic centers across the state to ensure continuous access between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays), for PCPs to obtain pediatric psychiatry consultation, including the following:

- immediate advice to the PCP (within 30 minutes of the contact);
- referral to the MCPAP Provider team care coordinator to assist in arranging and linking to Behavioral Health services;
- referral of the child to team therapist for transitional counseling while Behavioral Health services are being arranged; or
- referral of the child to the team child psychiatrist for diagnostic or psychopharmacologic consultation.

Perform the following MCPAP responsibilities, without limitation:

- Ongoing collection of Encounter data pursuant to the Contractor’s requirements;
- Conducting ongoing outreach to recruit and enroll PCP practices and build relationships with PCPs in a MCPAP Provider’s center;
- Informing PCPs in a MCPAP Provider’s region how to access MCPAP services;
- Regular communication with PCPs regarding satisfaction with MCPAP;
- Regular communication with PCPs who underutilize MCPAP to identify barriers to using the MCPAP service;

Maintenance of up-to-date and comprehensive information for PCCs on access to Network Behavioral Health Providers;

Maintenance of a dedicated website about MCPAP that provides information about MCPAP and information about children's behavioral health topics and resources for PCPs and families for approval by EHS.

Provide quarterly aggregate progress reports to EOHHS and DMH 20 days after the closing of each quarter, which shall include the following data elements at a summary level for each month in the quarter:

Number and names of MCPAP Providers;

Number and names of PCPs enrolled in MCPAP;

A list of pediatric MassHealth PCCs, noting which PCCs have enrolled in MCPAP and which PCCs have not yet enrolled and noting efforts to enroll each unenrolled PCC;

For each MCPAP Provider and statewide: number of Encounters by type of Encounter, diagnosis, reason for contact, insurance status of the child, and name of the PCP;

For each MCPAP Provider and statewide: unduplicated count of children served, by type of Encounter, diagnosis, reason for contact, insurance status of the child, and name of PCP;

Number of Encounters of unduplicated Members, by MCPAP Provider;

Report of outcome, diagnosis, and medication per consultation;

Number of enrolled PCPs, by MCPAP Provider;

Revenue generated by billing insurers, including Mass Health and MassHealth MCOs, for direct face-to-face treatment to children and families by MCPAP Provider and statewide;

Annualized budgets for each MCPAP Provider and MCPAP Administration; and

Other program utilization data elements as identified by EOHHS, MCPAP and DMH.

EOHHS and DMH may at their discretion require additional MCPAP reporting requirements in addition to the reporting requirements set forth in **Sections 4.5.H.1-11** above.

Coordinate all MCPAP program activities with DMH, including but not limited to:

Attending monthly planning meetings and other meetings as required by DMH;

Establishing and regularly convening a MCPAP Advisory Committee to inform and advise the MCPAP Unit and DMH on program improvements and direction;

Revising program activities as requested by DMH and approved by EOHHS; and

Participating in any DMH-initiated program evaluation activities and accompanied recommendations for future direction.

Participate in national initiatives and consortiums of children's Behavioral Health consultation and collaboration programs as directed by EOHHS.

In Contract Year Four, establish and maintain a network of MCPAP for Moms Providers to provide consultation to adult primary care providers, OB/GYN providers and psychiatrists to address the needs of mothers at risk for, or experiencing, postpartum depression. In addition the Contractor shall:

1. Provide orientation and/or training in postpartum depression screening, brief intervention and referral for supportive and treatment services (when indicated) for OB/GYNs and MCPAP-enrolled pediatricians.
2. Continue enrollment of OB/GYN practices in MCPAP for Moms to address Covered Individuals' postpartum behavioral health needs.

As directed by EOHHS, participate in a DMH work group to develop financial and programmatic strategies to ensure sustainability of MCPAP within the context of alternative payment and service delivery methodologies associated with healthcare.

By the end of Contract Year Four, submit to EOHHS and DMH for review and approval a report to increase the utilization of MCPAP services at the practice and provider level. The report shall include:

1. An analysis of the current utilization and trends in the utilization of the MCPAP services at the practice and provider level;
2. An analysis of the results of the most recent annual PCP Satisfaction survey;
3. A description of the methodology used to quantify practice and provider utilization of MCPAP; and
4. Strategies to increase the effective utilization of MCPAP services.

In Contract Year Four, implement strategies to increase pediatricians' capacity to identify, provide brief intervention, and refer for treatment adolescents with substance use needs. The Contractor shall:

1. Contract with an Adolescent Substance Use Screening and Treatment Specialist for this initiative who will train all MCPAP Hubs staff in the new S2BI algorithm (a new validated screening tool for adolescent substance use developed by Dr. Sharon Levy of Boston Children's Hospital) and use of the revised SBIRT Toolkit. The MCPAP Hub staff shall maintain logs of the practices and providers they train;
2. Oversee MCPAP Hubs staff in training pediatric practices enrolled with their respective MCPAP Hubs in the new S2BI using the revised SBIRT Toolkit;

3. The MCPAP Hubs will provide contact information between enrolled pediatric practices and other SBIRT training and information resources in the state; and

4. Submit to EOHHS and DMH quarterly and annual reports, stratified by months and year to date, on aggregate de-identified adolescent substance use encounters by MCPAP Providers statewide, provided that such report will not include identifiable data except to the extent permitted by law and requested by EOHHS. The design of the report shall be submitted within 30 days of the beginning of Contract Year Four and be consistent with the requirements and be approved by DMH and EOHHS.

By the end of Contract Year Four, develop and implement for EOHHS and DMH's review and approval, strategies to increase pediatricians' capacity to identify and treat the Behavioral Health needs of children ages five and under and their families. To develop such strategies the Contractor shall:

1. Submit quarterly and annual reports (stratified by months and year to date) to EOHHS and DMH on early childhood Behavioral Health Encounters by MCPAP Providers statewide. The design of the report shall be submitted within 30 days of the beginning of Contract Year Four and be consistent with the requirements and approval of DMH and EOHHS.

2. By the end of Year Four, complete the statewide training plan described in **Section 4.5.N**. to implement the Positive Parenting Program (Triple P) within MCPAP teams, pediatric practices and community-based Behavioral Health agencies.

3. By the end of Year Four, Quarter 2, complete the Triple P technical assistance described in **Section 4.5.N**. with all accredited Triple P providers, utilizing Triple P trainers for 50% of monthly sessions.

4. Organize Peer Support groups for actively practicing accredited Triple P providers to promote sustainability of the clinical model post-grant funding.

5. For the first two quarters of Contract Year 4, submit quarterly and semi-annual report (stratified by months and year to date) to DMH on participation of parents in a Triple P Positive Parenting Program. The design of the reports will be submitted within 30 days of the beginning of Contract Year Four and be in accordance with the requirements specified by DMH.

Evaluate the implementation of the Triple P intervention. The Contractor shall:

1. Design an evaluation instrument to be approved by EOHHS and DMH to evaluate the implementation of the Triple P Positive Parenting Program training. The instrument shall include:

   a. Key indicators;

   b. Measures of success; and

c. Data collection plan.

2. By the end of Quarter 3 of Contract Year Four, complete the evaluation of the implementation Triple P intervention.

3. By the end of Contract Year Four, submit final report to EOHHS and DMH following the specifications of the evaluation instrument.

Forensic Evaluations

Forensic Evaluations are a clinical assessment of mental status that enables local police departments to obtain psychiatric hospitalizations, when appropriate, for persons who are arrested but not yet arraigned because the court is closed.

The Contractor shall provide a system to access Designated Forensic Professionals (DFPs) for Forensic Evaluations conducted as part of a Pre-Arraignment Protocol (PAP) as described in M.G.L. c. 123, § 18(a) (see **Appendix A-6)**. After the Contractor has conducted an initial clinical evaluation of an individual who has been arrested but not yet arraigned, the Contractor shall determine the need for further evaluation for hospitalization and issue a referral for a Forensic Evaluation. Upon receiving a referral for a Forensic Evaluation, the DFP shall:

Evaluate the arrested individual, generally at the hospital Emergency department or in a police lock-up, through an interview and other available clinical data;

Determine whether the individual is in need of hospitalization and that no other alternatives are feasible; and

Present this finding to an on-call judge who is empowered to issue a temporary commitment to a DMH facility or to Bridgewater State Hospital.

Money Follows the Person Demonstration

The Money Follows the Person (MFP) Demonstration is designed to assist individuals participating in the Demonstration to transition from long term care facility settings to community-based settings. Individuals participating in the MFP Demonstration that enroll in an MFP HCBS Waiver are MFP Waiver Participants. MFP Waiver Participants who are not otherwise eligible for managed Behavioral Health benefits through either the Contractor or an MCO are Covered Individuals for the purpose of this **Section 4.7**.

The Contractor shall:

1. At the request of an MFP Waiver Case Manager, provide referral assistance to in-network behavioral health providers, provide case consultation, and accept and review referrals for care management for high risk individuals to determine the MFP Waiver Participant's clinically indicated Behavioral Health needs;

2. Work with the MFP Waiver Case Manager to determine care needs, and in collaboration, develop a course of treatment (i.e. individual service plan), and provide a set of services (recommend and assist with arranging and provide authorization when appropriate), based upon the individual clinical needs of the MFP Waiver Participant including, if clinically indicated, Clinical Service Coordination as described in Section 6.3;

3. When clinically indicated, refer the MFP Waiver Participant to an in-network Community Support Program to conduct a Behavioral Health Assessment;

4. Provide information regarding the MFP Waiver Program, including coverage information to contracted providers;

5. Instruct contracted providers, where applicable, to include the MFP Waiver Case Manager on the team if a multidisciplinary care team is convened;

6. Monitor the MFP Waiver Participant's Individual service plan and continue collaboration and on-going communications with the MFP Waiver Case Manager;

7. Communicate the individual service plan to and coordinate such plan with the appropriate agencies, organizations and providers; and

8. Provide an update of the MFP Tracking Report on a monthly basis.

9. Submit an application to EOHHS for enrollment as a provider of MFP Demonstration Transitional Assistance Services.

At the request of EOHHS, the Contractor shall train MFP Waiver Case Managers, and any other individuals that MassHealth identifies, contracts with or appoints to aid in transitioning MFP Waiver Participants from nursing facilities or hospitals. Such training shall include, at minimum:

a description of the purpose and goals of the Behavioral Health program and available services and support;

identification of the Network Providers available through the Contract;

a description of how to make appropriate referrals;

a process for making such referrals; and

contact information for dedicated Contractor staff that MFP Waiver Case Managers can contact to appropriately and efficiently refer an MFP Waiver Participant.

Once MassHealth determines that Covered Individual is eligible for the MFP Waiver program, the Contractor shall, within 60 days of a planned discharge:

1. Accept referrals from the MFP Waiver Case Manager; work with the MFP Waiver Case Manager to determine care needs, and identify potential behavioral health services needed, and determine what services are available in the expected community location;

2. As requested by the MFP Waiver Case Manager, provide a list of in-network behavioral health providers, provide case consultation, and accept and review referrals for care management for high risk individuals to determine the need for pre-transition referrals to in-network Community Support Program to conduct a Behavioral Health Clinical Assessment and/or referral to in-network behavioral health providers for pre-transition services. Pre-transition referrals shall be made no more than 60 days prior to the planned discharge date.

3. Payment for all in-network behavioral health services provided pre-transition shall be made in accordance with Section 10.17.

Social Innovation Financing for the Chronically Homeless Program (SIF Program)

The Commonwealth is implementing its Social Innovation Financing for Chronic Homelessness Program (SIF Program), a Housing First model, and has procured an entity to facilitate this implementation (SIF Intermediary). The Contractor shall support the SIF Program as described in this section.

A. The Contractor shall enter into good faith negotiations with SIF Program providers identified by EOHHS and, provided such negotiations are successful, execute and maintain Network Provider contracts with SIF Program providers identified by EOHHS to provide Community Support Program (CSP) services as set forth in **Appendix A-1** and below; provided, however, that such Network Providers must meet all applicable Contract, statutory, and regulatory requirements. The Contractor shall pay its contracted SIF Program providers a case rate consistent with the current market rate for the services in **Section 4.8.C** below for each day a Covered Individual is a SIF Program participant.

B. SIF Program participants shall be those Covered Individuals whom the SIF Intermediary refers to the Contractor (a "referral"). The Contractor shall accept from the SIF Intermediary referrals that identify Covered Individuals, including veterans, who are SIF Program participants. Such referrals shall only be for Covered Individuals who either:

1. Meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, i.e., is an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years; or

2. Are identified by SIF Program providers and approved by the SIF Intermediary as an individual who is homeless and a high-cost user of emergency services.

The Contractor may also work with the SIF Intermediary and SIF Program providers to develop a process for the Contractor to refer Covered Individuals to the SIF Intermediary and SIF Program providers who the Contractor believes may qualify to be SIF Program participants.

C. Subject to Medical Necessity requirements, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall authorize, arrange, coordinate, and provide to Covered Individuals who are SIF Program participants Community Support Program (CSP) services as set forth in **Appendix A-1** in a manner consistent with the goals of the SIF Program. Such CSP services shall consist of face-to-face, intensive, and individualized support, as described by EOHHS, which shall include:

1. Assisting SIF Program participants in enhancing daily living skills;
2. Providing service coordination and linkages;
3. Assisting SIF Program participants with obtaining benefits, housing and healthcare;
4. Developing a crisis plan;
5. Providing prevention and intervention; and
6. Fostering empowerment and recovery, including linkages to peer support and self-help groups.

D. The Contractor shall work with EOHHS to take all steps and perform all activities necessary to implement the above requirements consistent with SIF Program goals, policies and procedures as communicated by EOHHS, including but not limited to participating in meetings with the SIF Intermediary."

Mobile Crisis Intervention/Runaway Assistance Program (MIC/RAP)

A. The Contractor (MBHP) shall ensure that its contracted Emergency Services Program Providers (ESPs) establish a "Mobile Crisis Intervention/Runaway Assistance Program" (MCI/RAP). Through this program, as further described in this **Section 4.9**, the ESPs shall provide a temporary and safe place for Youth as defined in **Section 4.9.B** below to stay on a voluntary basis, until such Youth is transferred to an Alternative Lock-up Program or other appropriate level of service in accordance with **Section 4.9.C.4**, below.

B. For the purposes of this **Section 4.9**, the following definitions shall apply:

1.Youth –

a. Any "Child Requiring Assistance" under Chapter 240 of the Acts of 2012, currently defined as a child between the ages of 6 and 18 who: (i) repeatedly runs away from the home of the child's parent, legal guardian or custodian; (ii) repeatedly fails to obey the lawful

and reasonable commands of the child's parent, legal guardian or custodian, thereby interfering with their ability to adequately care for and protect the child; (iii) repeatedly fails to obey the lawful and reasonable regulations of the child's school; (iv) is habitually truant; or (v) is a sexually exploited child; or

b. Any minor between the ages of 7 and 18 who has been arrested by police for a non-violent offense.

2. MCI/RAP site – the site the ESP maintains to operate the MCI/RAP in accordance with **Section 4.9.C.2** below. Such site may be the same site as the ESP location.

3. Non-Court Hours – Hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically Monday through Friday between 4:30 PM and 8:30 AM, weekends, and holidays.

C. Implementation of MCI/RAP

In implementing the MCI/RAP, the Contractor shall require its contracted ESPs to:

1. Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.

2. Maintain a MCI/RAP site where police can bring Youth during Non-Court Hours.

3. Greet police officers and Youth who come to the MCI/RAP site during Non-Court Hours.

4. Supervise Youth brought by a police officer to the MCI/RAP site on at least a one-to-one basis until the Youth:

   a. Is transferred to a hospital level of care;

   b. Is transferred to the care of Alternative Lock-up Program (ALP) staff; or

   c. Voluntarily leaves the site.

5. If a Youth who was brought to the MCI/RAP site chooses to voluntarily leave the site,

   a. Immediately notify the police department of the city or town where the MCI/RAP site is located and the Department of Children and Families (DCF) (if the Youth is known to be in DCF custody), of the youth's departure,

b. Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123, §12, and, if determined appropriate , apply for hospitalization of such Youth; and

c. Submit a critical incident report form to the Contractor. The Contractor shall submit such report to EOHHS.

6. Designate a manager to oversee the MCI/RAP. The manager shall:

   a. Ensure MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court Hours and be available to MCI/RAP staff for consultation;

   b. Provide back-up coverage for on-call MCI/RAP staff;

   c. Train program staff regarding MCI/RAP procedures;

   d. Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP; and

   e. On the following business day, follow up with the police department that transported the Youth to the MCI//RAP site, and follow-up with any ALP to which the Youth was transferred.

D. Implementation Timeline

1. On November 5, 2014, the Contractor shall ensure that at least two of its contracted ESPs to operate the MCI/RAP in accordance with this **Section 4.9**.
2. From January 1, 2015 through March 31, 2015, the Contractor shall:

   a. Allow, but not require, additional contracted ESPs to operate the MCI/RAP.

   b. With support from EOHHS, arrange at least one statewide meeting with all contracted ESPs to discuss full implementation of the MCI/RAP.

3. On April 1, 2015, the Contractor shall ensure that all of its contracted ESPs operate the MCI/RAP in accordance with this **Section 4.9.**

E. MCI/RAP Outreach and Training

As directed by EOHHS, the Contractor shall provide additional outreach and training to contracted ESPs and other stakeholders, including:

1. Meeting with the ESPs, police and probation officers, and ALPs to discuss the MCI/RAP;
2. In conjunction with EOHHS and its designees (such as Mass211), hosting statewide trainings or conferences, in addition to requirements outlined in Section 9 of this Contract; and

3. Training Contractor staff on MCI/RAP.

F. MCI/RAP Outcome and Output Measures

The Contractor shall require its contracted ESPs to provide quarterly and annual reports to the Contractor, who will report to EOHHS, in a form and format agreed upon by the Contractor and EOHHS, on outcomes and outputs related to the MCI/RAP, including but not limited to:

1. The number of Youth who receive a crisis intervention assessment;
2. Demographics related to Youth served including but not limited to age, gender, ethnicity and city/town of residence
3. The number of Youth unable to be maintained safely at the MCI/RAP site and require further assessment in the secure environment of the emergency department;
4. The number of Youth transferred to the care of Alternative Lock-up Program (ALP) staff; and
5. The number of Youth who voluntarily leave the MCI/RAP site.

G. Contractor Payment to ESPs for MCI/RAP

1. Each state fiscal year, the Contractor shall pay each contracted ESP $35,476.00 for its operation of the MCI/RAP.
2. The Contractor shall make the payments in **Section 4.9.G.1**, and shall account for any other costs associated with operation of the MCI/RAP, using only the payments EOHHS provides the Contractor in accordance with **Section 10.12** and the Contractor's own funds. The Contractor shall not use any other payments EOHHS provides the Contractor in accordance with **Section 10** to operate the MCI/RAP. Unless specifically directed to do so by EOHHS, the Contractor shall not include the Contractor's costs and expenditures related to the MCI/RAP in its Encounter Data submitted to EOHHS and such costs and expenditures shall not be considered when calculating any payment pursuant to the risk sharing arrangement in **Section 10.6** and **Appendix H-1**.**"**

Reporting

The Contractor shall submit to EOHHS all required reports related to clinical service and utilization management under the Contract, as described in this **Section 4** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

PCC PLAN MANAGEMENT SUPPORT SERVICES

Overview

The Contractor shall assist EOHHS in the management of the PCC Plan by providing certain administrative functions, as described in this section, on behalf of EOHHS.

PCC Plan Management Support Services Staffing and Staff Training

The Contractor shall:

Employ appropriately qualified staff experienced in supporting providers in the areas of transformation, integration and general primary care support functions in sufficient numbers to satisfy all responsibilities. Staff shall include the following positions, unless otherwise approved by EOHHS.

1. **PCC Plan Provider Partner Support Services Director –** dedicated solely to the Contract; responsible for all applicable Provider Partner Support Services activities as described in **Section 5.**
2. **PCC Plan Provider Partner Support Specialists-**dedicated solely to the Contract , with appropriate provider management, QM, provider relations, and relevant background and experience; responsible for conducting activities on behalf of EOHHS as described in **Section 5.3**, including an onsite presence at EOHHS, if requested to assist with any duties performed by EOHHS related to PCC support and education.

Ensure that all MBHP staff providing services under this Contract are informed about relevant aspects of MassHealth policy changes, including but not limited to EOHHS payment reform and integration initiatives, or other skills associated with this Contract. Within two months of the first day of each Contract Year, in consultation with EOHHS, determine the need for training some or all Contractor staff in relevant aspects of MassHealth policy updates, payment reform and integration initiatives, or other skills associated with this Contract and, if necessary, develop and provide such training within a timeline agreed upon with EOHHS.

Annually, within the first three months of the first day of the Contract Year, develop a plan for training and enhancing staff performance on all functions associated with the PCC Plan Management Support Services. Training material must receive prior review and approval from EOHHS.

PCC Plan Management Support Services (MSS) Program

PCC Plan Management Support Services (MSS)

The Contractor shall:

Establish, implement and maintain a PCC Plan Management Support Services (MSS) program for PCCs that measures, monitors and promotes

improvements in health care delivery systems, including integration of care, at the PCC practice level;

Review, update, and establish any new written standard operating policies and procedures for the Contractor's staff associated with the PCC Plan (PPSS) program;

Provide to EOHHS copies of the standard operating policies and procedures for the PCC Plan PPSS program within six months of the first day of the Contract Year and modify such policies and procedures in support of the PCC Plan as directed by EOHHS;

Accept and utilize any data files that EOHHS provides in connection with the MSS program, in the format determined by EOHHS;

Notify EOHHS if, after diligent effort on the part of the Contractor, a PCC refuses to cooperate with the MSS profiling process or other Contract requirements;

Develop and implement written action plans, as needed, related to reports produced for PCC Services locations. Prior to disseminating such reports, the Contractor shall certify the accuracy of the data to EOHHS regarding these reports as required in Section 11.1.B; and

Provide support to PCCs consistent with integration of Behavioral Health and medical care services.

PCC Performance Dashboard

PCC Performance Dashboard (PD)

The Contractor shall:

a. Utilizing data files provided by EOHHS, create a web-based PCC-specific PCC Performance Dashboard (PD) for all PCCs and/or PCC Service Locations with PCC Plan panels that meet the threshold number of Enrollees as agreed to by EOHHS and the Contractor, and other PCCs, as requested by EOHHS; the PD shall be implemented and updated according to a schedule determined by EOHHS;

b. Produce the PDs as requested by EOHHS;

c. Ensure the PDs are formatted in a user-friendly style approved by EOHHS;

d. One month prior to the dissemination of the PD, prepare for EOHHS's prior approval a written user's guide that explains the purpose of the report and the information it contains;

e. Include in each PD PCC-specific site information and PCC panel Enrollee demographics;

f. Include in each PD all measures provided by EOHHS. Measures shall be reported by both PCC and PCC Service Location level, when applicable. Such measures are subject to change during the term of the Contract. For each measure the Contractor shall:

1) Present PCC-specific data; and

2) Compare each PCC's performance using appropriate benchmarks and trended indicator rates as directed by EOHHS, such as:

a) aggregate PCC Plan performance;

b) available national, state, local or industry benchmarks; and

c) the PCC's PD trended data.

g. Include in the PD a one-page summary of trended rates for the PCC and by PCC Service Location for all clinical measures, as appropriate; compare the Service Location rates to that of the PCC entity, other PCC Service Locations, the overall PCC Plan rates, and other benchmarks as directed by EOHHS.

h. Deliver PDs to PCCs and PCC Service Locations through a password-protected, web-based portal prior to the Performance Dashboard site visits required by **Section 5.2.C.2**.

i. Within one business day of posting the updated PD (in accordance with **Section 5.2.B.2.a**), notify PCCs and PCC Service Location via email that the reports are available.

j. Design and propose for EOHHS approval additional clinical indicators that address medical and Behavioral Health integration, including but not limited to:

1) Acute inpatient admission over time by Enrollees;

2) Psychiatric inpatient admission over time by Enrollees;

3) Pharmacy utilization; and

4) Other measures.

k. Maintain a secure website that provides PCCs and PCC Service Locations access to all current PD reports and ensure that the current PD reports remain posted until the next cycle's PD is released. The Contractor shall ensure that PCC-specific PDs are not available to others by establishing and maintaining a secured system of log-in identification and passwords which may be set by the PCC or PCC Service Location for accessing its PCC-specific PD.

EOHHS and the Contractor may negotiate alternate PD measures, report formats, methods and timeframe for the production and distribution of the PD. The Contractor shall create and distribute the PD in accordance with any alternate measures as approved by EOHHS.

Additional Reports

The Contractor shall propose to EOHHS additional reports to support the PCC MSS, as appropriate.

The Contractor shall produce additional PCC MSS reports, including but not limited to analysis of trends identified from PCC MSS data, and other supplemental and management reports as negotiated by the parties.

EOHHS may at its discretion instruct the Contractor to replace the production of certain existing reports with reports generated for PCCs and PCC Service Locations as part of other EOHHS programs and/or initiatives (e.g., PCPR).

PCC MSS Site Visits

PCC MSS Introduction Visit

The Contractor shall:

Within three months after a new provider has become a PCC, conduct a PCC MSS introduction visit, regardless of the PCC's enrollment roster/panel size.

Ensure that the MSS introduction visit includes:

An introduction to the Contractor and a description of the Contractor's role and the PCC Plan MSS;

The current EOHHS and PCC Plan goals and policies;

A description of available Contractor programs, including but not limited to, the PCC Plan ICMP, ESP, NAL, etc.

A description of all appropriate materials that are used in the PCC Plan MSS.

The PCC's Regional Network Manager's name, telephone number, and e-mail address;

The PCC Hotline number and a list of reasons a PCC might want to call the PCC Hotline; and

Time frames for the PCC's or PCC Service Location's expected initial MSS site visit; and

A description of any additional reports and/or information as directed by EOHHS.

PCC MSS Site Visits

After the introduction visit, the Contractor shall conduct PCC MSS site visits according to an EOHHS-approved schedule. The Contractor shall review the needs of the PCC or PCC Service Location prior to scheduling a site visit, including PCC-specific and/or PCC SL-specific data, and shall conduct site visits to PCCs and PCC Service Locations as appropriate, or as requested by the PCC or PCC Service Location.

The Contractor shall develop and propose for EOHHS's approval a detailed plan for MSS site visits to all PCCs and PCC Service Locations that meet the site visit criteria agreed to by EOHHS. Such proposal shall include, at a minimum, the following elements:

1) A schedule for MSS site visits that is specific to each PCC and PCC Service Location, based on the agreed-upon site visit criteria and the PCC's performance, as set forth in the PCC-specific reports;
2) The criteria by which PCCs and PCC Service Locations will be evaluated for modification of their current MSS site visit schedule;
3) Timeframes for when PCCs and PCC Service Locations will be evaluated for modification of their current site visit schedule;
4) The content and subject matter of the site visits or, for those PCCs that may not receive a visit, other communications;
5) A description of how the Contractor will support PCC questions regarding Claims payment or other PCC Plan services not managed by the Contractor;
6) A description of how the Contractor will prioritize integration of Behavioral Health and medical care, and Care Management efforts for Enrollees as part of each site visit;
7) A method for documenting the site visits and the communications that have taken place with PCCs and PCC Service Locations;
8) A method and timeframe for evaluating the success of and improving MSS site visits under the Contractor's proposal; and
9) A description of any additional reports and/or information as directed by EOHHS.

Subject to EOHHS approval, the Contractor shall implement its MSS site visit proposal.

The Contractor shall work with PCCs and PCC Service Locations to schedule a convenient time for MSS site visits.

The Contractor shall make best efforts to involve the medical director of the PCC in the site visit, and shall advise the PCCs and PCC Service Locations that appropriate clinical and non-clinical staff should attend the site visit.

The Regional Network Manager shall discuss other related PCC issues as identified by the PCC or the Regional Network Manager, or as directed by EOHHS.

The Regional Network Manager shall conduct the MSS site visit and other EOHHS or Contractor staff shall attend, at the discretion of EOHHS.

At each PCC MSS site visit, the Regional Network Manager shall review with the PCC any new PCC MSS Support Materials along with the catalog, which includes instructions for ordering new and existing material, as described in **Section 5.2.D.1**, below.

The Contractor shall inform PCCs and PCC Service Locations that they may call the PCC Hotline to order additional copies of PCC MSS Support Materials (see **Section 5.2.D**), and shall furnish such materials upon request.

The Contractor shall maintain and document ongoing communication with PCCs and PCC Service Locations through additional site visits, email, and telephone follow-up, as appropriate or as directed by EOHHS.

The Contractor and EOHHS may negotiate a modified schedule and methodology for PCC MSS site visits and, with EOHHS approval, the Contractor shall perform MSS site visits in accordance with such alternate schedule and methodology.

The Contractor shall prepare, deliver to, and discuss with PCC Plan staff a detailed report of site visits on a monthly basis. The Contractor and EOHHS may negotiate report format and contents during the term of the Contract."

PCC MSS and BH Joint Visits

The Contractor shall develop and propose for EOHHS's approval a detailed plan for PCC MSS and BH joint site visits. Such proposal shall include, at a minimum, the following elements:

The criteria by which joint visits will be conducted;

The content and subject matter of the site visit;

A description of how the Contractor will support PCC questions regarding Claims payment or other PCC Plan services not managed by the Contractor;

A description of how the Contractor will support integration of Behavioral Health and medical care, and Care Management efforts for Enrollees as part of each site visit;

A method of documenting the site visits and the communications that have taken place with PCCs and PCC Service Locations, such as the PCC MSS database; and

A method and timeframe for evaluating the success of and improving joint site visits under the Contractor's proposal. The evaluation of success shall be based on information in the PCC MSS database.

PCC Compliance with PCC Provider Contract with EOHHS

The Contractor shall:

Develop and propose to EOHHS for review and approval a process for annually reviewing the compliance of selected PCCs with certain identified requirements in their PCC Provider Contracts (**Appendix C-2**), as well as other requirements specified by EOHHS;

Annually submit a report to EOHHS documenting the process used to monitor compliance of those PCCs identified in subsection **1** with the PCC Provider Contract and the Contractor's findings regarding PCC compliance;

Assist PCC Plan staff with ensuring that all providers who wish to remain in the PCC Plan network sign and return to EOHHS new PCC Provider Contracts whenever MassHealth updates such contracts; and

Perform all follow-up activities in connection with subsection **3**, as directed by EOHHS.

PCC Capacity

The Contractor shall report to EOHHS at least quarterly or as otherwise directed by EOHHS, in a format agreed to by EOHHS, the following:

A geographic access report for adult PCCs and PCC Service Locations and pediatric PCCs and PCC Service Locations demonstrating access by geography; and

A PCC-to-Enrollee ratio report showing open and closed adult PCCs and PCC Service Locations and pediatric PCCs and PCC Service Locations per number of Enrollees.

The Contractor shall monitor Enrollees' voluntary changes in PCCs and PCC Service Locations to identify Enrollees with multiple and frequent changes in PCCs in order to address opportunities for Enrollee education about the benefits of developing a consistent, long-term patient-doctor relationship with one's PCC.

The Contractor shall contact Enrollees who make frequent PCC changes to determine whether the Enrollee could benefit from a range of interventions, including Care Management.

PCC Plan Network Access and Availability

The Contractor shall ensure that all Enrollees have access to Medically Necessary MassHealth Covered Services that are the subject of this Contract. Access in this context refers to the ability of the Enrollee to obtain services at the time such services are needed. Such service refers to both telephone access and ease of scheduling an appointment. Availability means the extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership. During the first year of the Contract, the Contractor shall collaborate with EOHHS to establish access and availability standards.

General

The Contractor shall monitor the PCC Plan's capacity to serve Enrollees in accordance with the access standards specified below in subsection **2** on a quarterly basis, or sooner where there is a significant change to either the PCC Plan or the PCC Plan Network that would affect the adequacy and capacity of services. Significant changes shall include, but are not limited to:

Changes in MassHealth Covered Services;

Enrollment of a new population in the PCC Plan; and

Changes in provider payment methodology.

Access and Time Standards

The Contractor shall monitor the PCC Plan Network to ensure that Enrollees have access to Covered Services 24 hours/seven days per week. Enrollees must be provided a telephone number to contact the PCC during the hours when the office is not open and the PCC shall respond to all such Enrollee calls within one hour.

In addition, the Contractor shall ensure that Enrollees receive Covered Services within the time periods provided below.

For physical health services:

Emergency Services: Immediately upon Enrollee presentation at the service delivery site.

Primary Care:

Within 48 hours of the Enrollee's request for Urgent Care Services;

Within 10 calendar days of the Enrollee's request for non-urgent symptomatic care; and

Within 45 calendar days of the Enrollee's request for non-symptomatic care, unless an appointment is required more quickly to assure the

provision of screenings in accordance with the schedule established by the EPSDT: Medical and Dental Protocol and Periodicity Schedules found in Appendix W of all MassHealth provider manuals, per 130 CMR 450.141.

For specialty care: Within appropriate time frames agreed to by EOHHS.

For Enrollees newly placed in the care or custody of DCF, who do not otherwise have emergent or Urgent Care needs:

Within seven calendar days of receiving a request from a DCF case worker, a DCF Health Care Screening shall be offered at a reasonable time and place. Such DCF Health Care Screening shall attempt to detect life threatening conditions, communicable diseases, and/or serious injuries, or indication of physical or sexual abuse;

Within 30 calendar days of receiving a request from a DCF case worker, a comprehensive medical examination, including all age appropriate screenings according to the EPSDT Periodicity Schedule shall be offered at a reasonable time and place.

For Poststabilization Care Services: Enrollees are provided with any necessary referrals for Poststabilization Care Services.

For all other services: In accordance with usual and customary community standards.

Payment Reform Initiative

Beginning Contract Year Four the Contractor shall be responsible for activities supporting the transformation to practice-based care from plan based care management, including support for MassHealth alternative payment initiative. The Contractor will deliver the following services related to Transformation and Integration of Care:

1. Contractor Support for practices participating in the Primary Care Payment Reform Initiative (PCPR), including:
    a. Qualitative evaluation of progress towards implementing patient-centered medical homes and behavioral health integration;
    b. Consulting with PCPR practices on practice identified opportunities related to behavioral health integration; and
    c. Reporting of Behavioral Health data related to PCPR panel enrollees to assist practices in managing under the PCPR payment model.
2. Support for evolving all PCCs capacity and competencies related to Behavioral Health Integration, including:
    a. Baseline assessment of levels of behavioral health integration throughout PCC Plan Network using simple, standardized survey consistent with AHRQ lexicon; and

   b. Delivery of practice consultation and provider education tailored to different levels of integration and related to financing, practice design, and workforce development for integrated care.

3. Support for the implementation of new initiatives related to PCCs, including by partnering directly with EOHHS in the design and introduction of such programs as they pertain to Transformation and Integration.

Integrated Care Management Program

1. Practice Based Care Management
   Beginning Contract Year Four, provide support to the ICMP team and assist with the expansion of the Practice Based Care Management Program (PBCM) in all regions, including providing technical assistance, compliance monitoring, dissemination and review of reports as directed by EOHHS and training/education as described in **Section 5.3.**

2. Plan Based Care Management
   Within two months of Contract Year Four, submit for approval a work plan that includes collaborating with PCC sites to gather information on preferred communication materials and information from the Contractor regarding the ICMP. Liaison with PCC practices to provide ICMP clinical records to practice on-site or by fax, in coordination with ICMP clinical staff. See **Section 5.3**

3. Education and Training
   PCC Plan PPSS will be responsible for the coordination of educational and training opportunities for PCCs and PBCMs. PCC Plan PPSS will collaborate with stakeholders and subject matter experts both internally and externally to identify relevant training topics that will support current and future EOHHS initiatives. These include:

   a. Conducting two webinars during Contract Year Four, addressing topics related to behavioral integration, care coordination, or other topics as approved by EOHHS; and

   b. Establishing and implementing educational opportunities, such as learning collaboratives, regional learning sessions, or other educational modes that support PCCs and PBCMs to engage in group learning and identified topics.

4. Other Activities Related to PCC Plan Support Including, but Not Limited to:

   a. PCC Plan PPSS representing the PCC Plan and EOHHS with respect to PCC Plan activities, at provider conferences, community agency meetings and other forums that require a PCC Plan presence, if requested or approved by EOHHS; and

   b. Establishing relationships with other EOHHS contractors (e.g. the Customer Service vendor) and referring PCCs to them in order to resolve questions and issues such as eligibility, claims and billing inquiries, provide file updates.

PCC Plan MSS Support Material

1. Within two months of Contract Year Three, the Contractor shall:
   a. Develop and produce a web-based Health Literacy Library to meet the diverse needs of the PCC Plan population for use by members, PCCs and BH providers.
   b. Beginning Contract Year Four, the Contractor shall continue to develop and update the Health Literacy Library as directed by EOHHS staff. Topics shall clearly and concisely describe relevant health education, including medical, behavioral health, substance use, wellness/prevention topic areas and the Contractor, when appropriate, will submit new or updated materials to EOHHS for prior approval.
   c. Beginning Contract Year Four, the Contractor will review with EOHHS the current PCC Plan PPSS Support Materials, at EOHHS request, to determine additional and/or replacement Support Material necessary to support improved Member experience and integration of physical and behavioral health care. The Contractor shall deliver materials for EOHHS approval within required timeframes, as determined by EOHHS.
   d. Provide storage to accommodate all of the PCC Plan PPSS Support Materials necessary to meet the needs of the Network Providers and PCC network.
   e. Maintain a sample original package of all PCC Plan PPSS Support Materials and an inventory of all PCC PPSS Support Materials including:
      1) A list of topics for which PCC Plan PPSS Support Materials are available; and
      2) The number of each item in the Contractor's inventory of PCC Plan PPSS Support Materials.

2. PCC Compliance With PCC Provider Contract With EOHHS

   The Contractor shall:

   1. Develop and propose to EOHHS for review and approval a process for annually reviewing the compliance of selected PCCs with certain identified requirements in their PCC Provider Contracts (**Appendix C-2**), as well as other requirement specified by EOHHS;
   2. Annually submit a report to EOHHS documenting the process used to monitor compliance of those PCCs identified in **subsection 1** with the PCC Provider Contract and Contractor's finding regarding PCC compliance;
   3. Assist PCC Plan staff with ensuring that all providers who wish to remain in the PCC Plan network sign and return to EOHHS new PCC Provider Contracts whenever MassHealth updates such contracts; and
   4. Perform all follow-up activities in connection with **subsection 3**, as directed by EOHHS."

Care Management Program (CMP)

Goal of Integrated Care Management Support

The goal of Integrated Care Management Support (ICMS) is:

1. The Contractor to provide direct-to-Provider practice transformation support services for established Practice Based Care Management (PBCM) programs and support the implementation of additional PBCMs throughout the Commonwealth, as described in **Section 5.3.B.1.h)** and **i)** and **Appendix G**, and,
2. The Contractor to provide Plan-based care management and care coordination (Integrated Care Management Program – ICMP) to identified Enrollees who have complex medical and/or Behavioral health needs and whose overall health care may benefit from the assistance of a care manager, as described in **Section 5.3.E**.

   The Contractor's ICMP shall identify Enrollees with health risks for both Provider PBCM and the ICMP. Care management services and care coordination for Enrollees will provide holistic coordinated health care, social supports, wellness & recovery tools, and assist Enrollees with identifying and using their medical home for treatment of behavioral health, substance use and/or medical conditions.

Integrated Design for Practice Based Care Management and Plan Based Care Management

1. The Contractor shall submit to EOHHS a work plan for Contract Year Four and each subsequent contract year including timelines, for expanding PBCM programs as described in Appendix G, providing on-going support for PBCM programs, and providing care management for Enrollees served in ICMP. Beginning Contract Year Four, the work plan shall be submitted, for review and approval, within two months of the first day of the Contract Year. This work plan shall:
   a) address a revised Care Management Program model that includes the diversity and range of Enrollees' health care needs for those Enrollees that would benefit from a PBCM program or ICMP,
   b) include prioritizing direct real-time Referrals to ICMP for high risk Members not served by PBCM programs and Primary Care Payment Reform (PCPR) care management programs,
   c) include a plan and timelines for transferring ICMP Participants to PBCM programs,
   d) include identifying through data analytics those Enrollees with complex behavioral health risk, substance abuse risk, and medical/primary care risk.
   e) address the transitioning of previous Enhance Care Coordination Enrollees into ICMP,

f) include a description and process for care coordination activities within ICMP for those Enrollees in need of primary complex care coordination,

g) address care management services for those Enrollees transitioning to the community from long term support services,

h) address the expansion of Practice-based care management programs throughout the Commonwealth, per Appendix G, to provide Care Management for Enrollees identified by the Contractor as high risk and eligible for care management,

i) include the supports and services offered by ICMP to Providers who request support from the Contractor for their practice based care management program, and

j) include an ICMP staffing plan with both professional licensed staff and para-professional staff that are Peer Bridger support/recovery staff and community health workers, including the functions to be performed by para-professional staff under the clinical supervision of licensed clinical staff. Licensed staff include behavioral health clinicians and nurses. All ICMP para-professional staff shall be employed directly by the Contractor. The work plan will also include the functions of the PCC Partner Specialists as an ICMP team member.

2. Until EOHHS approval of the work plan for the Contract Year Four, the Contractor shall implement the existing Care Management Program under the leadership of a multidisciplinary medical and Behavioral Health team that includes a diverse staff with the appropriate skills to deliver clinical and non-clinical components of the program, including the Engagement of Enrollees into the ICMP.

3. Within one month of the first day of Contract Year Two, the Contractor shall submit to EOHHS the policies and procedures for daily operation of the Care Management Program.

4. The Contractor shall specifically tailor the Care Management provided to improve the health outcomes of each Participant, including such items as the frequency and intensity of interventions, and ensuring that the staff assigned to the Participant is appropriate based on each Participant's particular needs. The Contractor shall educate all Participants in self-care strategies, illness prevention and Wellness Program activities, and ensure that staff assigned to the Participant have knowledge of community-based services and supports.

5. The Contractor shall include in each Participant's plan a range of Care Management activities that may vary in frequency or intensity depending on the Participant's clinical needs.

6. The Contractor shall assign a registered nurse, or a behavioral health licensed care manager who shall oversee their assigned caseload, perform

direct clinical activities and oversee all care coordination or support activities performed by a Peer Bridger or Community Health Worker.

7. Within six (6) months of the beginning of Contract Year Four, the Contractor shall evaluate the current ICMP electronic system for tracking, profiling and managing Participants, including but not limited to face-to-face, telephonic, home visits, e-mail, texts, and mail encounter(s) between the care manager and the Participant and submit to EOHHS the results of the evaluation including a proposal, if applicable, to utilize a new electronic system.

C. Identification and Engagement of Enrollees for Practice Based Care Management and Plan Based Care Management

The Contractor shall:

1. Use a predictive modeling tool that incorporates health claims data in its algorithm to stratify high risk Enrollees for consideration into a PBCM or ICMP. EOHHS may in its sole discretion instruct the Contractor to use EOHHS's risk stratification of the PCC Plan for the Care Management Program. EOHHS may also request from the Contractor its risk stratification data on Enrollees.
2. In accordance with the definition for Engagement, Engagement shall include documented completed contact with a Participant, or care management/care coordination activity on behalf of a Participant, no less than once each month, driven by the Participant's comprehensive health assessment and the Individual Care Plan (ICP). At minimum, documented face-to-face or telephonic completed contact with a Participant must occur every sixty (60) days.
3. Beginning Contract Year Four, the Contractor shall:
    a. Serve a minimum number of unduplicated active Engaged Participants as described in **Appendix G-3**; and
    b. Enrollees receiving only care coordination by the Contractor including those Enrollees served within the Pediatric Behavioral Health Medication Initiative Program (PBHMI), as described in **Section 5.3**, shall not be included as an Engaged Participant.
4. ICMP shall accept referrals from EOHHS, the Contractor's staff, PCCs, state agencies, Enrollees, other providers, hospital discharge planners, Network Providers, or other knowledgeable sources to identify Enrollees who might be appropriate for Care Management and use the Health Needs Assessment (HNA) tool to identify Enrollees who may want to participate in Care Management.

5. Draft for EOHHS's approval an annual letter to all Enrollees, PCCs, and Behavioral Health network providers explaining the Care Management Program in sufficient detail so that Enrollees, PCCs, and Behavioral

Health Network Providers understand the program, and provides sufficient information on how to participate. Submit the draft letter for EOHHS review and approval within one month of the beginning of each Contract Year.

6. Submit to EOHHS for approval within one month of the start of each Contract Year a work plan for outreach to and engagement of identified or referred Enrollees. This plan must include, but is not limited to, protocols for written and oral attempts to engage nonresponsive Enrollees, those who decline to participate, documentation of all outreach attempts, and strategies to assist practice based providers with engagement of Enrollees, into their care management program.

Document the Participant's verbal consent to participate in the Care Management Program, noting the date consent was given, the Care Management staff to whom the consent was given, and, to the extent that the person giving consent is not the Participant, document the name of the person giving consent and the authority of that person to do so (e.g., "parent" or "guardian," etc.). Additionally, send a letter to the Participant explaining the Care Management Program in sufficient detail so that the Participant understands the program for which the verbal consent was given and provide sufficient information so that the Participant may opt out.

D. Assessment of Enrollee for Practice Based Care Management and Plan Based Care Management

1. Prior to an assessment for the ICMP, the Contractor shall ensure that Enrollees eligible for participation in a PBCM care management program will not be assessed by ICMP.

2. The Contractor shall ensure that an assessment by appropriate health care professionals is conducted for Enrollees in need of care management by the PBCM or ICMP to identify ongoing special conditions of an Enrollee in Care Management. The Care Management assessment shall include the following components:

   a. Assessment of an Enrollee's physical and Behavioral Health status including cognitive functioning and condition-specific issues;

   b. Assessment of the Enrollee's health care utilization patterns, including ED visits, types and variety of providers who have treated the Enrollee with the diagnoses;

   c. Documentation of clinical history, including medications;

   d. Assessment of activities of daily living;

   e. Assessment of life planning activities;

f. Evaluation of cultural and linguistic need, preferences or limitations; and

g. Evaluation of caregiver resources and natural community supports.

3. A licensed behavioral health clinician or a nurse supervisor will determine if an Enrollee is in need of ICMP intensive care coordination activities with limited or no care management. All care coordination activities will be documented in an electronic system.

E. Development, Implementation and Monitoring of an Individual Care Plan (ICP) for Practice Based Care Management and Plan Based Care Management

The Contractor shall:

1. Develop required ICPs for, and with, Participants receiving ICMP care management and ensure that an ICP is developed by PBCMs for their Participants. Ensure that the ICMP care manager coordinates a Participant's care across the Contractor's staff, including BH service authorization and BH Utilization Management, and utilizes a multidisciplinary Care Team that includes the Participant, the PCC, and others who are stakeholders in the Participant's care (e.g., family members, Peer Supports, BH Providers or other specialists, state agency case managers and/or service providers, and other community supports), as agreed to by the Participant;
2. The ICP shall address the Participant's specific medical and BH care needs and shall include the following components:
   a. Long- and short-term goals that seek to reduce the risk and help manage the complexity of the Participant's health conditions;
   b. Identification of barriers to meeting goals and consideration of the Participant's ability to adhere to treatment plans;
   c. Development of a schedule for follow-up and ongoing Participant assessment and communication;
   d. Development and communication of self-management and Wellness plans for Participant;
   e. Assessment of progress toward meeting goals established in the ICP; and
   f. Behavioral Health Crisis Prevention Plans as appropriate.
3. Initiate activities, as indicated in the ICP, related to clinical care management to ensure:
   a. Medication review and reconciliation;
   b. Communication with other treating providers and other supports identified by the Enrollee;

c. Care transition planning; and

d. Education on self-management of chronic conditions.

4. Initiate activities, as indicated in the ICP, to ensure Enrollees' timely and coordinated access to Primary, medical specialty and BH care, such as:

   a. Reinforcement of PCC, specialists or other Network Provider instructions;

   b. Guidance and assistance with obtaining a PCC/medical home for Enrollees when needed,

   c. Assistance in scheduling appointments;

   d. Well-visit and preventive care self-management reminders;

   e. Medical and BH appointments reminders and confirmation with the Participant that appointments have been kept;

   f. Wellness activities (e.g., smoking cessation, weight loss, etc.); ~~and~~

   g. Confirmation with Enrollees that they are adhering to medication recommendations; and

   h. Facilitating communities of social supports available for Enrollees

5. Provide the Participant with the opportunity to sign off on and/or verbally agree to the ICP goals and treatment plan prior to the implementation of such plan;

6. On at least a monthly basis, assess and monitor each Care Management Participant's ICP to ensure that the goals set forth in the ICP are met, the Participant's compliance is monitored, recommendations for follow-up and all ICP activities are documented in the Participant's ICP.

F. Ongoing Care Management and PCC Plan Partner Support Activities for Practice Based Care Management and Plan Based Care Management

The Contractor shall:

1. Assist Providers and Enrollees in the development of an appropriate ICMP discharge plan when the Enrollee changes treatment settings or is admitted to an in-patient treatment program. The development of a discharge plan shall occur prior to an Enrollee's hospital or long term care setting discharge or change in treatment setting, in coordination with appropriate staff, including but not limited to discharge planners, care managers, staff, the Enrollee's PCC, and other Network Providers. Where possible, the care manager should be present at Discharge Planning meetings

2. Ensure that PBCM programs develop appropriate discharge plans for their Enrollees transitioning between treatment settings,

3. Complete discharge plans for continuity of care for Enrollees who transition from ICMP to PBCM programs;

4. Ensure PCC Partner Specialists work with the ICMP to assist with:
    a. strengthening ICMPs relationships with PCCs,
    b. increasing number of PCC providers to operate their own practice based care management programs,
    c. Supporting PCCs with the implementing of new PBCM programs,
    d. Monitoring compliance of PBCM programs with care management activities, and
    e. Triaging, managing, and coordinating with ICMP of PCC inquiries, requests, and/or concerns regarding practice based care management programs or other requirements as described in **Section 5.3.C.4.**
5. Provide on-going ICMP clinical updates and coordination of care activities to PCCs and behavioral health (BH) providers on ICMP Enrollees with complex conditions. Document any clinical information received from the PCC or BH provider in the ICMP record. Clinical information to PCCs may be made telephonically, through face to face contacts, by mailings or fax, or as otherwise agreed upon with the PCC. Ensure PBCM programs provide and document clinical updates and coordination of care activities for their Enrollees.
6. Prioritize scheduled home visits and face-to-face contacts with ICMP Enrollees at highest risk, with complex conditions. Face-to-face contacts may be determined as necessary for successful Enrollee engagement and/or tenure. The face-to-face contact can occur in other community or inpatient settings, if necessary and appropriate;
7. Facilitate communication among the ICMP Enrollee, the PCC, the Network Provider and other specialty providers, and the Enrollee's support network, as identified by the Enrollee, who are involved in the Enrollee's health care, to promote service delivery coordination and improved outcomes; ensure the PBCM programs facilitate communication and service delivery coordination to improve outcomes for their Enrollees,
8. Collaborate with staff in other state agencies, community service organizations and providers that are already involved in meeting the Enrollee's needs or that may be helpful in meeting those needs; ensure the PBCM programs collaborate with all involved parties for their Enrollees,
9. Monitor medical and pharmacy utilization for ICMP Enrollees through claims data obtained from EOHHS and appropriately update the ICP and/or coordinate follow-up care as indicated through data received.
10. Educate and provide to the ICMP Enrollee and provider, as appropriate, EOHHS-approved informational materials created by the Contractor or obtained from external sources, about the ICMP Enrollee's medical or BH condition;

11. Document activities related to the provision of Care Management to ICMP Enrollees and share progress reports with care team members, with written consent from the Enrollees, if required by law; and
12. Prior to any disclosures regarding an Enrollee made during the provision of Care Management services, obtain written consent if required by law, and maintain a copy of it in each individual Enrollee's files at the Contractor's principal place of business, to the extent required by law.

G. ICMP and Transition to Practice-Based Care Management

1. The Contractor shall provide all contracted ICMP services to PCC Panel Enrollees that are not associated with a Provider with practice based care management, as agreed upon between Contractor and the Provider. These services include, but are not limited to, the identification of Enrollees for outreach and engagement in the ICMP through predictive modeling, acceptance of referrals from PCCs, Enrollees or other providers for participation in the ICMP, communication with Enrollees and Providers about ICMP, sharing the ICP with the Enrollee's PCC for those Enrollees enrolled in the ICMP, and implementing/evaluating the ICP with the Enrollee.
2. Starting Contract Year Four following approval by EOHHS, the Contractor shall provide a Transition/Discharge summary from the ICMP when an Enrollee transitions to the Provider's practice based care management program. ICMP staff will also meet with Providers regarding transitioning Enrollees, to encourage a seamless transition and continuity of care.
3. The Contractor shall cease all engagement activities to Enrollees associated with a PBCM program and will provide the PBCM program a monthly list of their Enrollees eligible for practice based care management.

H. ICMP and Transition to Primary Care Payment Reform Care Management

1. Beginning Contract Year Four following approval by EOHHS, the Contractor shall provide a Transition/Discharge summary when an ICMP Enrollee transitions to the PCPR's care management program. ICMP staff will also meet with the PCPR Providers regarding transitioning Enrollees, when possible, to encourage a seamless transition and continuity of care.

2. The Contractor shall cease outbound calls to Enrollees associated with a PCPR Provider's care management program when requested by EOHHS or the PCPR provider, to avoid engaging the Enrollee in the ICMP, and will provide the PCPR provider, upon request, a list of their Enrollees eligible for practice based care management.

Reporting

The Contractor shall submit to EOHHS all required reports related to clinical service and utilization management under the Contract, as described in this Section 5 or in Appendix E-1, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B.**

INTEGRATION OF CARE

Overview

The Contractor shall promote integration of medical and Behavioral Health care across the Contract by increasing communication and collaboration between health care providers who treat the same Member. The Contractor shall develop an organizational structure that promotes such integration of care through: new or enhanced communication and information sharing among PCCs and Network Providers; measurement and improvement of health outcomes; and the provision of Care Management services that support Covered Individuals and providers in their efforts to coordinate care.

The Contractor shall appropriately staff these efforts with a combination of clinicians, professionals and paraprofessionals to conduct the activities described in this **Section 6**.

Integration of Medical and Behavioral Health Care

Goal of Integration

The Contractor shall make best efforts to ensure the integration of medical and Behavioral Health care provided to Covered Individuals, and to ensure that such care is:

patient-centered, strength-based and recovery-oriented (if appropriate);

accessible (e.g., hours, communication methods);

driven by clinical and care issues and functions, and not practice and administrative issues;

integrated within practices or facilities as well as across practices and care settings;

integrated across both physical and Behavioral Health settings; and

focused on information sharing (process, clinical, and health outcomes) across physical and Behavioral Health systems at the state level.

Integration of Care Activities

The Contractor shall conduct the following activities, at a minimum, to promote coordination and collaboration among PCCs and Network Providers in the care they provide to Covered Individuals:

Educate Contractor staff on all MassHealth Covered Services provided to Covered Individuals;

Design, with input from Network Providers and PCCs and other Primary Care Practitioners, develop and implement policies that promote communication, coordination and collaboration across medical and Behavioral Health care providers; including a process for Providers to obtain consent, if required, from Covered Individuals to release information to other providers involved in the care.

Contact Covered Individuals to:

discuss the importance of information sharing among Providers in order to best integrate Covered Individuals' medical and Behavioral Health care; and

obtain verbal consent to participate in Care Management and care coordination programs.

Facilitate specific communication and coordination of a Covered Individual's Behavioral Health and Primary Care with the Network Provider, the PCC or other Primary Care Practitioners, and the Covered Individual;

Coordinate BH Covered Services with other MassHealth Covered Services, any other non-MassHealth services, and programs delivered to Covered Individuals, in concert with the natural community supports identified by the Covered Individual, as necessary and appropriate;

At the direction of EOHHS, within four months after the start of Contract Year 3, submit for EOHHS review a plan to measure and improve the rate at which PCCs receive timely information about their patients' use of Emergency Departments (ED) and inpatient admissions, and implement the plan upon EOHHS approval.

On a quarterly basis, evaluate the frequency and quality of interactions of Network Providers and PCCs and other Primary Care Practitioners regarding Covered Individuals, and develop and implement policy and process improvements based on these evaluations;

Educate PCCs and Network Providers on pharmaceuticals used for BH, in coordination with and support of the MassHealth Pharmacy Program (see **Section 4.4**);

Educate PCCs and Network Providers regarding the need to coordinate and manage prescribed medication use for BH and medical conditions, in coordination with and support of the MassHealth Pharmacy Program;

The Contractor shall monitor the PCCs and BH Network Providers and conduct support activities to assist providers in implementing best practices for integration of care through, at a minimum:

Regular screenings by PCCs to identify Behavioral Health risk factors;

Sharing of information through the PCC Performance Dashboard, Member-Level Report, and PCC Plan PCMHI reports, as described in **Section 5.2.B**;

Sharing of information through BH Network reports**;**

Outcome measurement; and

Information, education and training in evidence-based practices, wellness programs, and chronic care management.

Utilize the Contractor's website, as described in **Section 7.1.G**, to:

provide PCCs and other non-Behavioral Health providers with easy access to BH referral sources, treatment options and crisis intervention protocols; and

provide BH Network Providers with information on how to access the MassHealth Customer Service vendor for Primary Care referral sources, community resources and acute and Urgent Care Services facilities.

provide Covered Individuals with user-friendly access to at least the following sections of the Contractor's website: the Member Engagement Center, Member medical and Behavioral Health Covered Services, Nurse Advice Line, community supports, self-referral to the CMP.

Educate Primary Care Practitioners serving children on the availability of psychiatric consultation through the MCPAP, described in **Section 4.5.**

Ensure that PCCs have access to Behavioral Health Network Providers, e.g., current Behavioral Health Provider Directory, PCC Hotline, Massachusetts Child Psychiatry Access Project.

Develop an annual full-day statewide training for all PCC and Behavioral Health Providers, approved by EOHHS, that focuses on medical and Behavioral Health integration, utilizing training modules based on collaborative team building and multidisciplinary treatment approaches. All PCCs and PCC-associated Service Locations and PCPs shall be invited and encouraged to attend the training. The plan for training and content shall be submitted to EOHHS for approval two months in advance of the training date.

Conduct two regional meetings per Calendar year of contracted Behavioral Health Providers, PCCs and PCC-associated Service Locations to discuss new initiatives, lessons learned, and challenges faced by Providers; the plan for the meeting and content shall be submitted to EOHHS for approval two months in advance of the meeting date

Attend and participate in all EOHHS meetings and workgroups as directed by EOHHS with a particular focus on workgroups targeting medical and Behavioral Health integration.

Prior to any disclosure of information identifying or concerning an Enrollee made during the provision of services under this **Section 6.1**, obtain written consent, if required by law, and maintain a copy of it in each individual Enrollee's files at the Contractor's principal place of business.

Clinical Service Coordination for Covered Individuals not enrolled in the PCC Plan, including children in DCF and DYS and Covered Individuals enrolled in the MFP Waivers.

The Contractor shall establish clinical protocols for providing Clinical Service Coordination to Covered Individuals:

When such Covered Individuals present with patterns or histories of:

high inpatient utilization;

ongoing active involvement with other state agency services and programs;

frequent ESP utilization;

utilization of both psychiatric inpatient and detoxification services; or

co-existing medical and Behavioral Health problems; or

When such Covered Individuals present to a Network Provider with complex child custody and placement issues that are adversely affecting the provision of Behavioral Health and medical services.

The Contractor shall accept referrals from EOHHS, Primary Care Practitioners, state agencies, Network Providers, MFP Case Management entity, or other knowledgeable sources identifying Covered Individuals who may be appropriate for Clinical Service Coordination as described in this **Section 6.3**.

Clinical Service Coordination shall include a specifically assigned Care Coordinator with the authority to authorize Covered Services, who shall convene an interdisciplinary team for service planning meetings. Such meetings shall include, as appropriate, involved Behavioral Health Providers, state agency representatives, Primary Care Practitioners, specialty medical providers, and children and their families. Service planning meetings are utilized to develop a plan that coordinates BH services with services provided by other state agencies involved with the Covered Individual. The Care Coordinator shall authorize and coordinate all services pursuant to such plan. The Care Coordinator shall also work directly with state agency representatives in coordinating care to expedite a timely community placement as part of the Discharge Planning activities described in **Section 4.3.C**.

The Contractor shall ensure that Clinical Service Coordination for Covered Individuals includes:

a service plan that addresses the Covered Individual's specific BH care needs, including short-term and long-term service needs and, as applicable, medical services the Covered Individual may require;

ensuring that the care plan is sent to the Primary Care Practitioner after receiving consent, if such consent is required;

facilitating a schedule of home visits and face-to-face contacts with the Covered Individual, if appropriate;

facilitating communication among the Covered Individual, Primary Care Practitioner, Network Providers and other specialty providers involved in the Covered Individual's health care, to promote service delivery coordination and improved outcomes;

providing linkages with staff in other state agencies and community service organizations that may be able to provide services the Covered Individual needs; and

assisting the Covered Individual to access Primary Care and medical specialty care.

Demonstration Programs

The Contractor shall propose demonstration programs, including at a minimum the two programs described in subsections **A** and **B**, below, to improve integration across Behavioral and medical health care for Covered Individuals, and shall implement them upon approval by EOHHS.

Medical Passports Program

Within the first six months of Contract Year One the Contractor shall propose ways the Contractor can effectively support the availability, completeness and usefulness of "medical passports" for Children in the Care and/or Custody of DCF, their providers, out-of-home placements and DCF. The Contractor's proposal shall be subject to EOHHS modification, in whole or in part. The Contractor shall implement the proposal as approved by EOHHS.

Access to Primary Care for Children in the Care and/or Custody of the Commonwealth

Within the first six months of Contract Year One the Contractor shall propose a plan for assisting Children in the Care and/or Custody of the Commonwealth to access Primary Care, including EPSDT periodic and inter-periodic screens and Medically Necessary follow-up Behavioral Health, medical and dental services. Such proposal shall include engagement of foster parents, DCF and others involved in the child's care. The Contractor's proposal shall be subject to EOHHS modification, in whole or in part. The Contractor shall implement the proposal as approved by EOHHS.

Reporting

The Contractor shall submit to EOHHS all required reports related to integration of care and the Care Management Program, as described in this **Section 6** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

MEMBER AND PROVIDER SERVICES

General Requirements

The Contractor shall establish and operate as of the Service Start Date a discrete Member (Covered Individual) and Provider Services Department dedicated to the Contract, responsible for assisting Covered Individuals, Network Providers, PCCs and other PCC Plan providers. The Member and Provider Services Department shall maintain coverage for a minimum of nine hours per day during normal business hours and shall answer 90 percent of all calls within 30 seconds.

Staffing

The Contractor shall:

Employ service representatives with appropriate education and work experience to successfully perform the responsibilities of the position as described in **Section 7.1.B**, and in sufficient numbers to respond to all incoming calls to the Member and Provider Services Department and to handle any written correspondence received;

Train and supervise the service representatives, consistent with **Section 2.2.G** and as follows. The Contractor shall:

Prior to the Service Start Date and thereafter on an ongoing basis, orient and train service representatives regarding their job responsibilities and all applicable Contract matters.

Ensure that all service representatives are cross-trained to handle non-clinical calls from Covered Individuals, Network Providers, PCCs and other PCC Plan providers, including calls related to MassHealth Covered Services, BH Network Provider access, and BH Claims payment.

Immediately refer clinical calls received in the Member and Provider Services Department to clinical staff with the appropriate clinical expertise for response and resolution.

Adequately supervise service representatives to ensure quality and consistency in the performance of their responsibilities.

Establish a schedule of intensive training for newly hired and current service representatives about:

when, where and how Covered Individuals may obtain EPSDT/PPHSD screenings and diagnosis and treatment services;

the Children’s Behavioral Health Initiative; and

the Contract's focus on integration of medical and Behavioral Health care and how the customer service representatives should incorporate integration into their contact with Covered Individuals, Network Providers, PCCs and other PCC Plan providers.

Develop a written curriculum for each training, which shall be reviewed and approved by EOHHS before use by the Contractor.

Adjust the number of service representatives to accommodate significant changes in phone call volume;

Empower service representatives to assist all callers as completely as possible and to handle all calls appropriately;

Develop a process with the MassHealth Customer Service vendor to assist in the resolution of calls that initiate with Member and Provider Services Department;

Ensure that all calls from all providers are resolved, to the maximum extent possible, by the same service representative who handled the initial call;

Have the capacity to respond to callers who speak languages other than English; and

Ensure that service representatives have online access to the following BH Network Provider database elements:

- Network Provider name;
- website;
- e-mail address;
- contracted services;
- site addresses (street address, town, ZIP code);
- site telephone numbers;
- site hours of operation;
- Emergency/after-hours provisions;
- professional qualifications and licensing;
- areas of specialty;
- handicapped accessibility; and
- cultural and linguistic capacity.

Ensure that service representatives have online access to MassHealth and PCC Plan provider database elements:

- Provider name;
- website;
- e-mail address;
- contracted services;
- site addresses (street address, town, ZIP code);
- site telephone numbers;
- site hours of operation;

- Emergency/after-hours provisions;
- professional qualifications and licensing;
- areas of specialty;
- handicapped accessibility;
- cultural and linguistic capacity;
- PCCs with open and closed panels, where "open panel" refers to those accepting any new patient, and "closed panel" refers to those that are limited to the current patients only.

Ensure that service representatives have online access to the following database elements for pharmacies:

Alphabetical listing of pharmacies included in MassHealth's network, with their addresses and phone numbers, as provided by EOHHS; and

Instructions for the Enrollee to select the Member Services menu option from the Contractor's toll-free telephone line (as described in **Section 9.7**) for assistance in finding a convenient pharmacy.

Orientation, Outreach, and Education to PCC Plan Enrollees

The Contractor shall:

For each new Enrollee who enrolls in the PCC Plan after the Service Start Date, but who has not been enrolled in the PCC Plan in the past six months, offer and make best efforts to provide to the Enrollee an orientation, by telephone or in person, within 30 days of the Enrollee's Effective Date of Enrollment in the PCC Plan. The Contractor shall submit to EOHHS for review and approval its orientation and outreach materials and phone scripts. Such orientation shall include, at a minimum:

How the PCC Plan operates, including the role of the PCC;

A description of MassHealth Covered Services and service limitations;

Information on participating PCC Plan Providers and how to access the provider directory either via the internet or in writing;

The value of screening and preventive care; and

How to obtain MassHealth Covered Services.

The Contractor shall also provide the orientation described in subsection **1**, above to parents or guardians of newborns that are enrolled in the PCC Plan, to the extent applicable. As part of such orientation, the Contractor shall confirm the selection or assignment to a pediatrician within the newborn's geographic area as an appropriate PCC.

The Contractor must provide a range of health promotion and Wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall:

Work with EOHHS to implement innovative Enrollee education strategies for Wellness care and immunizations, as well as general health promotion and prevention, and Behavioral Health rehabilitation and recovery;

Work with PCCs and specialists, as appropriate, to integrate health education, Wellness and prevention training into the care of each Enrollee;

Participate in any EOHHS-led joint planning activities with MassHealth-contracted MCOs to develop and implement statewide or regional approaches to Enrollee health and Wellness education;

Provide condition- and disease-specific information and educational materials to Enrollees, including information on its Care Management Program described in **Section 6.2**; and

Provide condition- and disease-specific information and educational materials to Covered Individuals.

Ensure, in accordance with 42 U.S.C. § 1396u-2(a)(5), that all written information for use by Enrollees and potential Enrollees is prepared in a format and manner that is easily readable, comprehensible to its intended audience, well designed, and includes a card or other notice instructing the Enrollee in multiple languages that the information affects their health benefit, and to contact EOHHS for assistance with translation.

Make best efforts to obtain updated contact information whenever the Contractor has been unable to contact an Enrollee as a result of undeliverable mail or an incorrect telephone number. On a monthly basis, notify EOHHS of all Enrollees whom the Contractor has been unable to contact. Such notification shall be in the format and process specified by EOHHS in consultation with the Contractor.

Health Needs Assessment

The Contractor shall:

Develop, implement, and maintain procedures for completing an initial Health Needs Assessment (HNA), within 60 days after an Enrollee's Effective Date of Enrollment in the PCC Plan, for each new Enrollee whose enrollment occurs after the Service Start Date but who has not been enrolled in the PCC Plan in the past six months.

Develop, and administer to the Enrollees described in subsection **1**, a template for HNAs, which shall include but not be limited to questions that assess Enrollee demographic characteristics, personal and family health history,

including Behavioral Health and self-perceived health status, to predict an Enrollee's likelihood of experiencing certain conditions. The template shall advise the Enrollee regarding how the information obtained from the HNA may be used and to whom it will be disclosed, including to EOHHS. The Contractor shall submit the HNA template to EOHHS for prior review and approval.

Make best efforts to ensure that the Contractor's information systems, and other records as appropriate, are updated whenever the Contractor and/or a Provider or PCC becomes aware that the Enrollee's health status has changed significantly from that indicated in the initial HNA;

Use the findings from the HNA to identify Enrollees who may benefit from Care Management as described in **Section 6.2**; and

Ensure that Enrollees who are identified as requiring a particular type of service are offered assistance in accessing those services, including Behavioral Health Covered Services.

Virtual Gateway My Account Page Application

With Enrollee consent, the Contractor shall assist Enrollees in providing MassHealth with their current address (residential and mailing), phone numbers and other demographic information including pregnancy, ethnicity, and race, by entering the updated demographic information into the change form via the My Account Page Application on the Virtual Gateway, as follows:

If the Contractor learns from an Enrollee or an authorized representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the Contractor obtains demographic information from the Enrollee or authorized representative, the Contractor shall provide such information to EOHHS by entering it into the change form via the My Account Page Application on the Virtual Gateway, after obtaining the Enrollee's permission to do so, and in accordance with any further guidance from EOHHS.

Prior to entering such demographic information, the Contractor shall advise the Enrollee as follows:

"Thank you for this change of address/phone information. You are required to provide updated address [phone] information to MassHealth. We would like to help you to do that so, with your oral permission, we will forward this information to MassHealth. You may also provide MassHealth with information about your race or ethnicity. This is not required, but it will help MassHealth to improve Member services. You have provided us with this information. If you do not object, we will pass that information on to MassHealth for you."

If the Contractor receives updated demographic information from a third party, such as a provider, a vendor hired to obtain demographic information, or through the post office, the Contractor must confirm the new demographic

information with the Enrollee and obtain the Enrollee's permission prior to submitting the information to EOHHS on the change form.

The Contractor shall ensure that all appropriate staff entering this information have submitted the documentation necessary to complete this function on the Virtual Gateway and completed any necessary Virtual Gateway training requirements.

Responsibilities of Service Representatives

Service representatives shall:

Determine the nature of all inquiries and respond appropriately;

Exhibit sensitivity to the cultural differences and needs of EOHHS's diverse populations;

Appropriately utilize the reference guide described in **Section 7.1.F**;

Work with Covered Individuals, Network Providers, PCCs, other PCC Plan providers and other individuals as necessary to resolve Complaints or questions where appropriate;

Enter pertinent call information accurately into the Contractor's call tracking system described in **Section 9.7.A.5**, and be able to access relevant information from previous calls;

Arrange for the mailing of Network Provider policies, procedures, billing instructions and other related materials to Network Providers who request them, within two business days of the request;

Arrange for the mailing of Covered Individual educational/informational materials, as appropriate;

Arrange for the mailing of MSS materials to PCCs and other PCC Plan providers that request them, within two business days of the request; and

Perform other related activities as directed by EOHHS.

Member and Provider Services Reference Guide

The Contractor shall:

Develop, and submit to EOHHS for review and approval no later than two weeks after the Service Start Date, a Member and Provider Services reference guide that includes protocols for promptly and accurately:

responding to and resolving Covered Individuals' questions and inquiries;

resolving Providers' questions and concerns;

responding to PCCs' questions and concerns related to the PCC Plan; and

providing seamless collaboration with the PCC Plan staff for resolution of issues raised by Providers and Enrollees.

The Member and Provider Services reference guide shall include detailed information on the Contractor's role in promoting the integration of medical and Behavioral Health care, and how the Contractor can support the Covered Individual, Network Providers, PCCs and other PCC Plan providers in achieving integrated care.

Maintain the Member and Provider Services reference guide, reviewing it annually, and updating it as necessary or upon EOHHS request.

Website

The Contractor shall:

No later than two months prior to the Service Start Date, develop and submit for EOHHS's approval a plan for a website containing information specifically related to the Contract.

Launch the website as of the Service Start Date, and maintain it subject to EOHHS's approval.

Provide a link from the website to EOHHS's website.

Include, at a minimum, the following on its website:

Culturally and linguistically competent information for Covered Individuals regarding services available through the PCC Plan's BHP;

A searchable BH Provider Network Directory that is updated at least monthly and as needed;

A searchable PCC Plan Provider Directory for non-BH providers that is updated at least monthly and more frequently as needed;

The BH Network Provider manual;

The PCC Plan Provider handbook;

The PCC Plan Member handbook;

BHP-only handbook for Covered Individuals that are not enrolled in the PCC Plan;

Educational materials and links to evidence-based practices;

Information and materials to support integration between Network Providers and PCCs; and

Community resources.

Develop and propose to EOHHS within six months following the Contract Start Date a secure Provider and Covered Individual portal as part of the website.

Not provide any link to the Contractor's corporate website on any part of the website, unless agreed to by EOHHS.

Not provide any link to any type of corporate promotion on any part of the website.

Verify and, consistent with **Section 11.1.B**, certify to EOHHS on a quarterly basis the accuracy of all information contained on the website.

Member Services for Covered Individuals

General Requirements

As of the Service Start Date, the Contractor shall:

Inform Covered Individuals of the Member Services menu option from the Contractor's toll-free telephone number, and that such number can be used by Covered Individuals to obtain general information about the PCC Plan's BHP;

Handle calls from Covered Individuals, family members, guardians, and other interested parties regarding BH Covered Services, Network Providers, and QM initiatives;

Monitor the quality and accuracy of information through a representative sample of 10 percent of all English-speaking and 10 percent of all Spanish-speaking Member Services calls received, or such other percentage agreed to by EOHHS;

Handle calls and questions from Enrollees regarding the Contractor's Care Management Program as described in **Section 6.2**;

Inform Covered Individuals of their legal rights when receiving BH treatment;

Develop and distribute to Covered Individuals materials, such as BH-related fact sheets, quarterly newsletters and Network Provider directories, and mail materials requested by Covered Individuals within one business day of the request;

As appropriate, refer Covered Individuals to other relevant resources, such as the MassHealth Customer Services line, for resolution of their issues or inquiries;

Have the ability to answer inquiries in the Covered Individual's primary language through an alternative language device or interpreter, and notify Covered Individuals of this capacity;

Provide all written materials produced by the Contractor for Covered Individuals in a manner, format and language that can be easily understood by persons

with limited English proficiency and translate such materials into all Prevalent Languages. Currently, Spanish and English are Prevalent Languages. If EOHHS notifies the Contractor that Prevalent Languages shall include additional languages, the Contractor shall submit a work plan to EOHHS within 60 days of the notice and shall comply with the work plan, as approved by EOHHS;

Notify Covered Individuals of the availability of written materials available in alternative formats – i.e., in a format that takes into consideration the special needs of those Members who, for example, are visually limited or have limited reading proficiency (e.g., Braille, large font, audiotape, videotape, or information read aloud) – and provide them in such formats upon request;

Include a notice indicating that enclosed materials are important and should be translated immediately, and that provides information on how the Covered Individual may obtain help with getting the materials translated. This message shall be written in the following languages: Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian and Vietnamese, and other languages as directed by EOHHS.

Resource Materials

General Requirements

The Contractor shall:

Subject to EOHHS approval, develop, produce and distribute to Covered Individuals written materials focusing on issues that reinforce Contract priorities and positive health outcomes for Covered Individuals, including educational materials relating to self-care, Behavioral Health conditions, integration of medical and Behavioral Health services, and other topics;

Submit a draft of the above materials to EOHHS for approval no later than six weeks before the planned production date, or as otherwise agreed to by EOHHS;

Produce and distribute the approved materials to PCC Plan Providers and Network Providers for sharing with Covered Individuals;

Accept materials from EOHHS and distribute them as directed by EOHHS;

Make all materials available to service representatives for distribution, and when community-based presentations are conducted;

Establish and maintain an inventory system to ensure the availability of all resource materials, including those identified in this subsection **B** and in subsection **D**. At a minimum, the system must monitor the types of materials in stock, quantities in stock, quantities of materials mailed, and to whom;

Share educational/informational materials electronically;

Work collaboratively with EOHHS to encourage paperless communication; and

Provide EOHHS with any Covered Individual education materials that are provided to individuals under age 21 and update and distribute such materials to describe EPSDT/PPHSD services as further directed by EOHHS.

Behavioral Health Network Provider Directory

The Contractor shall:

As of the Service Start Date, develop and make available a Network Provider Directory that identifies the Contractor's Network Providers, including, at a minimum, physicians and hospitals. The directory shall include the following information:

Network Providers with areas of special experience, skills and training, including Providers with expertise in treating:

children and adolescents;

persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with Serious Mental Illness;

Homeless persons;

persons with Dual Diagnosis; and

other specialties.

office addresses and telephone numbers for each Network Provider;

office hours for each Network Provider, including the names of any Network Provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

the cultural and linguistic capabilities of Network Providers, including languages spoken by the Network Provider or by skilled medical interpreter at the Network Provider's site;

Network Provider licensing information;

whether the Network Provider is accessible for people with physical disabilities;

Network Provider access by public transportation.

Maintain an up-to-date version of the Network Provider Directory on the Contractor's website that is available to the general public. The web version of the Network Provider Directory should include the capability to search by:

name

town;

ZIP code;

Provider specialty;

languages spoken; and

Provider licensing information.

Within a reasonable time after EOHHS enrolls a new Covered Individual pursuant to **Section 12.3.A**, provide each such individual with notification that a copy of the Network Provider Directory can be accessed online at the Contractor's website, or available in writing by calling the Member and Provider Services Department;

At EOHHS's discretion, provide written notice to Covered Individuals of any changes in the Network Provider Directory at least 30 days before the intended effective date of the change or as soon as the Contractor becomes aware of such change;

In the event of the termination of a Network Provider, provide written notice within 15 days after receipt or issuance of the termination notice to each Covered Individual who was seen within the previous 90 days by the terminated Provider, and ensure that care is transferred to another Network Provider in a timely manner to minimize any disruptions to treatment;

Provide annual notification to Providers, PCCs, Covered Individuals and other interested parties that the most current version of the Network Provider Directory is available on the Contractor's website and that hard copies are available on request.

Community Events

The Contractor may conduct or participate in community events (i.e., forums sponsored by the Contractor or other entities that are not organized for the primary purpose of promoting the Contractor's services) at which the Contractor may present information about EOHHS's PCC Plan or BH services or distribute EOHHS-approved materials, only when the following requirements are met:

For Contractor-sponsored community events, the Contractor shall:

At least 20 business days in advance, submit to EOHHS for review and approval any proposed community event and a description of the event, including the time, date, location and expected attendance; and

Invite EOHHS staff and representatives from EOHHS's Customer Services program to attend at no cost.

For community events not sponsored by the Contractor, the Contractor shall:

At least 20 business days before the event, submit to EOHHS a request for approval to participate in the scheduled community event or, if the Contractor is made aware of the event less than 20 business days in advance, as soon as the Contractor determines that it plans to attend; and

Provide a description of the event, including the time, date, location and expected attendance, with the name and phone number for the person or organization responsible for organizing it.

Marketing Activity Requirements

General Requirements

The Contractor's Marketing activities, if any, must comply with the provisions of 42 CFR 438.104. In conducting any Marketing activities described herein, the Contractor shall:

Ensure that all Marketing Materials regarding the Contractor's services under this Contract clearly state that information regarding all MassHealth Managed Care enrollment options including, but not limited to, this Contractor, are available from the MassHealth Customer Service Center. The Contractor shall ensure that all written Marketing Materials prominently display the telephone number and hours of operation of the MassHealth Customer Service Center in the same font size as the same information for the Contractor. EOHHS, in its sole discretion, may exempt, in writing, promotional materials or activities from this requirement upon written request by the Contractor;

Submit all Marketing Materials to EOHHS for approval 60 days prior to distribution or as early as possible;

Distribute and/or publish Marketing Materials statewide, unless the Contractor submits a written request which is approved by EOHHS to implement a targeted Marketing campaign. A targeted Marketing campaign involves distributing and/or publishing materials to a region or part of a region of the state, or, where the campaign relates to a local event (such as a health fair) or to a single Provider (such as a hospital or clinic), to a certain ZIP code or ZIP codes.

Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval.

Permissible Marketing Activities

The Contractor may engage in only the following Marketing activities, in accordance with the requirements stated in subsection **D.1**, above.

The Contractor may participate in a health fair or community activity sponsored by the Contractor, provided that the Contractor shall notify all MassHealth-contracted MCOs within the geographic region of their ability to participate. Such notification shall be in writing and shall be made as soon as reasonably possible prior to the date of the event. If other MassHealth-contracted MCOs choose to participate in a Contractor's sponsored event, they shall contribute to the costs of such event as a condition of participation, provided costs are reasonably apportioned among the MassHealth-contracted MCOs. The Contractor may conduct or participate in Marketing at Contractor- or non-Contractor-sponsored health fairs and other community activities only if:

Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and

Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in the PCC Plan.

The Contractor shall participate in health benefit fairs sponsored by EOHHS.

The Contractor may market to Covered Individuals, in accordance with subsection **D.1**, above, by distributing and/or publishing Marketing Materials or implementing a targeted Marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing Marketing Materials may include:

Posting written Marketing Materials that have been pre-approved by EOHHS at Network or PCC Provider sites and other locations; and posting written promotional Marketing Materials throughout the state;

Initiating mailing campaigns that have been pre-approved by EOHHS, where the Contractor distributes Marketing Materials by mail; and

Television, radio, newspaper, website postings, and other audio or visual advertising.

Prohibitions on Marketing and Enrollment Activities

The Contractor shall <u>not</u>:

Distribute any Marketing Material that has not been pre-approved by EOHHS;

Distribute any Marketing Material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the Marketing Material, including but not limited to any assertion or statement, whether written or oral, that:

The recipient of the Marketing Material must enroll in the PCC Plan in order to obtain benefits or in order to not lose benefits; or

The Contractor is endorsed by CMS, the federal or state government or similar entity.

Seek to influence a Member's enrollment in the PCC Plan in conjunction with the sale or offering of any non-health insurance products (e.g., life insurance);

Seek to influence a Member's enrollment into the PCC Plan in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts;

Directly or indirectly, engage in door-to-door, telephonic, or any other cold-call marketing activities ("cold-call marketing" includes any unsolicited personal contact by the Contractor with a Covered Individual who is not enrolled with the BHP that can reasonably be interpreted as intended to influence the individual to enroll in the PCC Plan or the BHP, or to not enroll in or to disenroll from a MassHealth MCO or the BHP);

Engage in any Marketing activities that could mislead, confuse or defraud Members or Covered Individuals, or misrepresent MassHealth, EOHHS, the Contractor or CMS;

Conduct any provider site Marketing, except as otherwise provided in **Section 7.2.D**;

Incorporate any costs associated with Marketing or Marketing incentives, or non-medical programs or services in the Contractor's cost reports;

Engage in Marketing activities that target Members on the basis of health status or future need for health care or Behavioral Health services, or which otherwise may discriminate against individuals eligible for health care services.

Marketing Plan and Schedules

The Contractor shall make available to EOHHS, for review and approval upon request, a comprehensive Marketing plan, including proposed Marketing approaches, current schedules of all Marketing activities, and the methods, modes, and media through which Marketing Materials will be distributed.

Annually, the Contractor shall present its Marketing plan in person to EOHHS for review and approval.

The Contractor shall annually submit to EOHHS a written statement including an executive summary of its MassHealth Marketing plans and a statement that all of its Marketing plans and Marketing Materials are accurate and do not mislead, confuse, or defraud Members or misrepresent the state, and are otherwise in accordance with the requirements of 42 CFR 438.104.

Information to Covered Individuals

Nothing herein shall be deemed to prohibit the Contractor from providing non-Marketing information to Covered Individuals consistent with this Contract regarding existing or new services, personnel, Covered Individual education materials, Care Management programs and Provider sites.

MassHealth Benefit Request and Eligibility Redetermination Assistance

The Contractor or Provider staff may help MassHealth applicants apply for MassHealth eligibility in the following ways. Such staff may:

Explain the MassHealth Benefit Request (MBR) and Eligibility Redetermination Verification (ERV) forms to applicants;

Assist MassHealth applicants in completing and submitting MBRs;

Offer to assist Enrollees with completion of the annual ERV form; and

Refer MassHealth applicants to the MassHealth Customer Service Center.

Network Provider Relations

General Requirements

As of the Service Start Date the Contractor shall:

Ensure that the Contractor's toll-free telephone number has a menu option for Network Provider Relations, and that such number can be used by Network Providers who need general assistance with the Contractor's policies or with Claims and billing inquiries and issues;

Utilize EOHHS's Eligibility Verification System (EVS) to facilitate the resolution of Network Providers' questions regarding eligibility and enrollment matters for Covered Individuals. The Contractor and Network Providers shall not require such verification prior to providing Emergency Services; and

Monitor a representative sample of a minimum of 10 calls per agent per month of all Provider calls received, or other sample size as directed by EOHHS, for consistency and accuracy of the information being provided.

Network Provider Concerns

The Contractor shall:

Maintain written policies and procedures for handling all Network Provider concerns appropriate to the Contract and make available to EOHHS upon request;

Notify Network Providers of the Contractor's toll-free number and that it can be used by Network Providers who need general assistance regarding Contractor policies and procedures;

Review the policies and procedures for handling Network Provider concerns at least annually, submitting the results of this review to EOHHS, and making improvements as appropriate;

Acknowledge, orally or in writing as the Contractor determines is appropriate, within 24 hours, the receipt of a Provider concern;

Create and maintain a log to document the type and nature of each concern, date of receipt, date of resolution, how each was addressed, whether orally or in writing, and what corrective action, if any, was taken;

Provide resolution summary, orally or in writing as the Contractor determines is appropriate, to Network Provider concerns within 15 days;

Designate a staff person(s) to be responsible for coordination, receipt and handling of Provider concerns; and

Provide a summary report to EOHHS of Provider concerns on a quarterly basis, or other schedule determined by EOHHS.

PCC Plan Provider Services

General Requirements

As of the Service Start Date the Contractor shall:

Establish and maintain the PCC Plan Hotline for PCCs and other PCC Plan providers to use for information related to the Contractor's responsibilities related to the PCC Plan, including reporting, Quality Management, operations, PCCs participating in PCMHI, and the PCC Plan Provider Contract (see **Appendix C-2**) and other topics as directed by EOHHS.

Ensure that the Contractor's toll-free telephone number (see **Section 2.1.A.2**) has a menu option for the PCC Hotline so that such number can be used by PCCs and other PCC Plan providers who need general assistance regarding PCC Plan operations and PCC QM issues as outlined in **Sections 5** and **8**;

Refer callers to the PCC Hotline to other resources, such as EOHHS or EOHHS's other contractors, as appropriate and in accordance with **Appendix C-9**;

Monitor a representative sample of a minimum of 10 calls per agent per month of all PCC Plan Hotline calls received, or other sample size as directed by EOHHS, for consistency and accuracy of the information being provided. The results shall be made available to EOHHS upon request.

PCC Plan Provider Concerns

The Contractor shall:

Handle PCCs' and other PCC Plan providers' concerns only as they relate to the responsibilities under MSS, Care Management, the PCC Hotline, the PCC Plan Quarterly newsletter and any other PCC Provider Contract issue, directing other PCC issues such as inquiries related to Claims payment or Grievances to EOHHS's Customer Services vendor in accordance with **Appendix C-9**.

Maintain written policies and procedures for handling all appropriate PCC and other PCC Plan provider concerns, and make them available to EOHHS upon request.

Review the policies and procedures for handling PCC and other PCC Plan provider concerns at least annually, submitting the results of this review to EOHHS PCC Plan staff. Propose improvements as appropriate and submit any proposed amendments to EOHHS for approval at least one month before the enactment date of the amendment, unless otherwise specified by EOHHS.

Acknowledge, orally or in writing as the Contractor determines is appropriate, within 24 hours, the receipt of a PCC or other PCC Plan provider concern.

Create and maintain a log to document the type and nature of each concern, date of receipt, date and method of acknowledgment, date of resolution, how each was addressed, whether orally or in writing, what corrective action, if any was taken, and a copy of any correspondence with the PCC or other PCC Plan providers.

Provide resolution summary, orally or in writing, as the Contractor determines is appropriate, to PCC and other PCC Plan provider concerns within 15 days.

Designate a staff person(s) to be responsible for coordination, receipt and handling of PCC and other PCC Plan provider concerns.

Document PCCs' and other PCC Plan providers' concerns in a PCC Plan MSS monthly report, report them to MassHealth's PCC Plan staff, and, when appropriate, propose solutions to MassHealth.

Work with EOHHS to determine which PCCs' and other PCC Plan providers concerns need to be elevated to the PCC Plan staff immediately for assistance in triage and resolution.

Provider and PCC Publications

PCC Plan Quarterly Newsletter

The Contractor shall:

On a quarterly basis, create, produce and electronically transmit or mail to each Network Provider and PCC a PCC Plan newsletter to be entitled "PCC Plan Quarterly," similar to the sample in **Appendix C-6**. Each issue shall include relevant information on Contractor efforts to enhance the

integration between medical and Behavioral Health care and the opportunities for support of PCCs and other Providers in the care of Enrollees who have complex medical and/or Behavioral Health care needs through the Care Management Program. EOHHS reserves the right to modify the name, format or content of this newsletter at anytime.

At least one time per year meet with MassHealth staff regarding the mission and themes for the upcoming year's newsletters.

Submit a written plan to EOHHS for approval regarding the formatting, production and distribution of the newsletter prior to each scheduled publication of "PCC Plan Quarterly" in a timeframe agreed to by EOHHS.

Prepare newsletter content as follows:

Collect potential article ideas consistent with the approved newsletter theme from appropriate sources.

Present all the potential article ideas to EOHHS for review and approval to be included in the upcoming newsletter.

Solicit authors for approved article ideas. (If an appropriate author cannot be identified, the Contractor may author the article.)

Edit articles submitted and review draft with appropriate stakeholders, including a medical professional, before submitting a final draft to EOHHS.

Format and design the layout of the newsletter such that it is visually appealing, using graphics and illustrations in the production of each issue, unless otherwise approved by EOHHS.

Print and distribute the "PCC Plan Quarterly" newsletter with EOHHS approval.

PCC Plan Member Newsletter

The Contractor shall

Two times a year, create, produce and mail to each PCC Plan Member case head a newsletter entitled "Health Highlights," similar to the sample in **Appendix C-7**. The "Health Highlights" newsletter shall focus on promoting and supporting EOHHS or PCC Plan initiatives, its quality improvement activities, the integration of medical and Behavioral Health care, and include information on MassHealth Covered Services as appropriate. EOHHS reserves the right to modify the name, format or content of this newsletter at anytime.

At least one time per year meet with EOHHS staff regarding the mission and themes for the upcoming year's newsletters.

Submit a written plan to EOHHS for approval regarding the formatting, production and distribution of the newsletter prior to each scheduled publication of "Health Highlights" in a timeframe agreed to by EOHHS.

Prepare newsletter content as follows:

Collect potential article ideas consistent with the approved newsletter theme from appropriate stakeholders.

Present all the potential article ideas to EOHHS for review and approval to be included in the upcoming newsletter.

Solicit authors for approved article ideas. (If an appropriate author cannot be identified, the Contractor may author the article.)

Edit articles submitted and review draft with appropriate stakeholders, including a medical professional, before submitting a final draft to EOHHS.

Format and design the layout of the newsletter such that it is visually appealing, using graphics and illustrations, unless otherwise approved by EOHHS.

Submit to EOHHS a proposal for review and approval if the Contractor would like to distribute "Health Highlights" electronically. Such a proposal must maintain the capability to mail "Health Highlights" to Enrollees who have not chosen to receive "Health Highlights" electronically.

Print and distribute "Health Highlights" with EOHHS approval.

PCC Plan Support Materials Catalog

On a semiannual basis, the Contractor shall develop, publish and distribute PCC Plan Support Materials Catalog in collaboration with EOHHS. (See also **Appendix C-9** and **Section 5.3**.)

Inquiries, Grievances, Internal Appeals, and BOH Appeals

General Requirements

Maintain written policies and procedures for:

The receipt and timely resolution of Grievances and Internal Appeals, as further described in **Section 7.6.B**, below. Such policies and procedures shall be approved by EOHHS; and

The receipt and timely resolution of inquiries, where timely resolution means responding to the Inquiry at the time it is raised to the extent possible or, if not possible, acknowledging the inquiry within one business day and making best efforts to resolve the inquiry within one business day of the initial inquiry. Such policies and procedures shall be approved by EOHHS.

Review the inquiry, Grievance and Internal Appeals policies and procedures established pursuant to subsection **1**, above, at least annually, to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS;

Create and maintain records of inquiries, Grievances, Internal Appeals, and BOH Appeals, using the health information system(s) specified in **Section 9.1.B.11**, to document:

The type and nature of each inquiry, Grievance, Internal Appeal, and BOH Appeal;

How the Contractor disposed of or resolved each Grievance, Internal Appeal, or BOH Appeal; and

What, if any, corrective action the Contractor took.

Report to EOHHS annually regarding inquiries, Grievances, Internal Appeals and BOH Appeals, as described in **Appendix E-1**;

Assure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any inquiry, Grievance, Internal Appeal, or BOH Appeal;

Provide Covered Individuals with information about Grievance, Internal Appeal, and BOH Appeal procedures and timeframes, as specified in **Section 7.6.B.2**; and

Provide information about Internal Appeals, Grievances and BOH Appeals to all Providers and Material Subcontractors at the time they enter into a contract with the Contractor.

Grievances and Internal Appeals

The Contractor shall maintain written policies and procedures for the filing by Covered Individuals or Appeals representatives and the receipt, timely resolution, and documentation by the Contractor of any and all Grievances and Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR Part 438, Subpart F. (For purposes of this section, in cases where a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment, or may appoint an Appeal representative to represent them, without parental/guardian consent.)

General Requirements

The Contractor shall put in place a standardized process that includes:

A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;

A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 7.6.B.2.a.3)** and **7.6.B.4,** below; and

A means for expedited resolution of Internal Appeals, as further specified in **Section 7.6.B.4.d**, when the Contractor determines (for a request from the Covered Individual) or a Provider indicates (in making the request on the Covered Individual's behalf or supporting the Covered Individual's request) that taking the time for a standard resolution, in accordance with **Section 7.6.B.4.a**, could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function.

The Contractor shall put in a place a mechanism to:

Accept Grievances filed either orally or in writing; and

Accept Internal Appeals filed either orally or in writing within 30 calendar days from the notice of Adverse Action, provided that if an Internal Appeal is filed orally, the Contractor must require the Covered Individual to submit a written, signed Internal Appeal form following the oral filing unless an expedited resolution is requested as specified in **Section 7.6.B.4.d**. Internal Appeals filed later than 30 days from the notice of Adverse Action may be rejected as untimely.

The Contractor shall send a written acknowledgement of the receipt of any Grievance or Internal Appeal to Covered Individuals and, if an Appeals representative filed the Grievance or Internal Appeal, to the Appeals representative and the Covered Individual within one business day of receipt by the Contractor.

The Contractor shall track whether an Internal Appeal was filed orally or in writing within 30 calendar days from the notice of Adverse Action specified in **Section 7.6.B.2**.

Notice of Adverse Action

The Contractor shall put in place a mechanism for providing written notice to Covered Individuals of any Adverse Action in a form approved by EOHHS as follows:

The notice must meet the language and format requirements specified in **Sections 7.1.B.4** and **7.2.A.9-11**.

The notice must explain the following:

The Adverse Action the Contractor has taken or intends to take;

The reason(s) for the Adverse Action;

The Covered Individual's right to file an Internal Appeal or to designate an Appeal representative to file an Internal Appeal on behalf of the Covered Individual;

The procedures for a Covered Individual to exercise his/her right to file an Internal Appeal;

The circumstances under which expedited resolution of an Internal Appeal is available and how to request it;

That the Contractor will provide the Covered Individual Continuing Services, if applicable, pending resolution of the first-level review of an Internal Appeal if the Covered Individual submits the request for the first-level review within 10 days of the Adverse Action;

That the Contractor will provide the Covered Individual Continuing Services, if applicable, pending resolution of the second-level review of an Internal Appeal if the Covered Individual submits the request for the second-level review within 10 days of the Contractor's decision resolving the first-level review; and

That the Contractor will provide the Covered Individual Continuing Services, if applicable, pending resolution of a BOH Appeal if the Covered Individual submits the request for the BOH Appeal within 10 days of receipt of notice of the Final Internal Appeal decision, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services.

The notice must be mailed within the following timeframes:

For termination, suspension, or reduction of a previous authorization for a requested service, at least 10 calendar days prior to the Date of Action in accordance with 42 CFR 431.211, except as provided in 42 CFR 431.213. In accordance with 42 CFR 431.214, the period of advance notice may be shortened to five calendar days before the Date of Action if the Contractor has facts indicating that action should be taken because of probable fraud by

the Covered Individual and the facts have been verified, if possible through secondary sources.

For denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials of payment where coverage of the requested service is not at issue, which include, but are not limited to, denials for the following reasons:

Failure to follow prior authorization procedures;

Failure to follow referral rules; and

Failure to file a timely claim.

For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 4.2A.2.e.1)**, as expeditiously as the Covered Individual's health condition requires but no later than 14 calendar days following receipt of the service request, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

The extension shall only be allowed if:

The Provider, Covered Individual or Appeal representative requests the extension, or

The Contractor can justify (to EOHHS, upon request) that:

(1) The extension is in the Covered Individual's interest; and

(2) There is a need for additional information where:
There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
Such outstanding information is reasonably expected to be received within 14 calendar days.

If the Contractor extends the timeframe, it must:

Give the Covered Individual written notice of the reason for the extension and inform the Covered Individual of the right to file a Grievance if the Covered Individual disagrees with that decision; and

Issue and carry out its determination as expeditiously as the Covered Individual's health condition requires and no later than the date the extension expires.

For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 4.2.A.1.e.2)**, as expeditiously as the Covered Individual's health requires but no later than three business days after the receipt of the expedited request for service, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

The extension shall only be allowed if:

The Provider, Covered Individual or Appeal representative requests the extension, or

The Contractor can justify (to EOHHS, upon request):

(1) The extension is in the Covered Individual's interest; and

(2) There is a need for additional information where:
There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
Such outstanding information is reasonably expected to be received within 14 calendar days.

If the Contractor extends the timeframe, it must do the following:

Give the Covered Individual written notice of the reason for the extension and inform the Covered Individual of the right to file a Grievance if the Covered Individual disagrees with that decision; and

Issue and carry out its determination as expeditiously as the Covered Individual's health condition requires and no later than the date the extension expires.

For standard or expedited service authorization decisions not reached within the timeframes specified in **Sections 4.2.A.1.e.1)** and **2),** whichever is applicable, on the day that such timeframes expire.

When the Contractor fails to provide services in a timely manner in accordance with the access standards in **Section 3.1.G**, within one business day upon notification by the Covered Individual or Provider that one of the access standards in **Section 3.1.G** was not met.

Handling of Grievances and Internal Appeals

In handling Grievances and Internal Appeals, the Contractor shall:

Inform Covered Individuals of the Grievance, Internal Appeal, and BOH Appeal procedures.

Give reasonable assistance to Covered Individuals in completing forms and following procedures applicable to Grievances and Internal Appeals, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TTD and interpreter capability;

Provide notice of Adverse Actions as specified in **Section 7.6.B.2**;

Accept Grievances and Internal Appeals filed in accordance with **Section 7.6.B.3**;

Send written acknowledgement of the receipt of each Grievance or Internal Appeal to the Covered Individual and Appeal representative within one business day of receipt by the Contractor;

Ensure that the individuals who make decisions on Grievances and Internal Appeals are individuals who were not involved in any previous level of review or decision-making;

Ensure that the following types of Grievances are decided by health care professionals who have the appropriate clinical expertise in treating the Covered Individual's medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance:

Grievances regarding the denial of a Covered Individual's request that an Internal Appeal be expedited, as specified in **Section 7.6.B.4.a.3)d)**; and

Grievances regarding clinical issues;

Ensure that the following special requirements are applied to Internal Appeals:

The Contractor shall offer two levels of review of an Adverse Action for standard Internal Appeals only;

All first-level reviews shall be conducted by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action;

The Contractor shall allow the Covered Individual or an Appeal representative to waive the second level of review and must notify the Covered Individual or an Appeal representative of this right in the notice of the Contractor's decision resulting from the first-level review;

The Contractor shall allow the Covered Individual or an Appeal representative to file a request for second-level review within 30 calendar days after the notice of the Contractor's decision resulting from the first-level review;

The second-level review shall be conducted by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action, and have not been involved in any prior review or determination in the Internal Appeal;

The Contractor shall treat an oral request seeking to appeal an Adverse Action as an Internal Appeal in order to establish the earliest possible filing date for Internal Appeals and may require the Covered Individual or an Appeal representative to confirm such oral requests in writing as specified in **Section 7.6.B.3.e**;

The Contractor shall provide a reasonable opportunity for the Covered Individual or an Appeal representative to present evidence and allegations of fact or law, in person as well as in writing, and shall inform the Covered Individual or an Appeal Representative about the limited time available for this opportunity in the case of expedited Internal Appeals;

The Contractor shall provide an opportunity for the Covered Individual and an Appeal representative, before and during the Internal Appeals process, to examine the Covered Individual's case file, including medical records, and any other documentation and records considered during the Internal Appeals process; and

The Contractor shall include, as parties to the Internal Appeal, the Covered Individual and Appeal representative or the legal representative of a deceased Covered Individual's estate.

Resolution and Notification of Grievances and Internal Appeals

The Contractor shall:

Dispose of each Grievance, resolve each Internal Appeal, and provide notice of each disposition and resolution, as expeditiously as the Covered Individual's health condition requires, within the following timeframes:

For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in

writing, from a valid party, e.g., the Covered Individual or the Covered Individual's authorized Appeal representative;

For standard resolution of Internal Appeals and notice to the affected parties, no more than 40 calendar days from the date the Contractor received either in writing or orally, whichever comes first, the Covered Individual request for a first-level Internal Appeal unless this timeframe is extended under subsection **4.b**, below. This timeframe shall exclude the time the Covered Individual took to file the second-level review as specified in **Section 7.6.B.3.h.4)**; and

For expedited resolution of Internal Appeals and notice to affected parties, no more than three business days from the date the Contractor received the expedited Internal Appeal unless this timeframe is extended under subsection **4.b**, below. The Contractor shall process the expedited Internal Appeal even if a Provider is allegedly serving as the Covered Individual's Appeal representative, but the Contractor has still not received in writing the Authorized Appeal representative form. The Contractor may require that the Provider submit a signed Authorized Appeal Representative form to the Contractor as documentation that the Covered Individual did in fact authorize the Provider to file the expedited Internal Appeal on the Covered Individual's behalf, as long as the expedited Internal Appeal is not delayed waiting for the Authorized Appeal Representative form;

Extend the timeframes specified in **Sections 7.6.B.4.a.2)** and **3)** as follows:

Extend the timeframe in **Section 7.6.B.4.a.2)** by up to five calendar days if:

The Covered Individual or Appeal representative requests the extension, or

The Contractor can justify (to EOHHS upon request) that:

The extension is in the Covered Individual's interest; and

There is a need for additional information where:

There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

Such outstanding information is reasonably expected to be received within five calendar days;

Extend the timeframe in **Section 7.6.B.4.a.3)** for up to 14 calendar days if:

The Covered Individual or Appeal representative requests the extension, or

The Contractor can justify (to EOHHS upon request) that:

The extension is in the Covered Individual's interest; and

There is a need for additional information where:

There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

Such outstanding information is reasonably expected to be received within 14 calendar days;

For any extension not requested by the Covered Individual, the Contractor shall provide the Covered Individual and Appeal representative written notice of the reason for the delay. Such notice shall include the Covered Individual's right to file a grievance;

Provide notice in accordance with subsection **4.a**, above, regarding the disposition of a Grievance or the resolution of a first- or second-level standard Internal Appeal or an expedited Internal Appeal as follows:

All such notices shall be in writing in a form approved by EOHHS, and for notice of an expedited Internal Appeal resolution, the Contractor must also make reasonable efforts to provide oral notice to the Covered Individual; and

The notice shall contain, at a minimum, the following:

The results of the resolution process and the effective date of the Internal Appeal decision;

For Internal Appeals not resolved wholly in favor of the Covered Individual:

The right to file a BOH Appeal and how to do so, and include the Request for a Fair Hearing form; and

That the Covered Individual will receive Continuing Services, if applicable, while the BOH Appeal is pending if the Covered Individual submits the appeal request to the BOH within 10 days

of the Adverse Action, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services.

Resolve expedited Internal Appeals as follows:

The Contractor shall resolve Internal Appeals expeditiously in accordance with the timeframe specified in subsection **4.a**, above, when the Contractor determines (with respect to a Covered Individual's request for expedited resolution) or a Provider indicates (in making the request for expedited resolution on the Covered Individual's behalf or supporting the Covered Individual's request) that taking the time for a standard resolution could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall process the expedited Internal Appeal even if the Provider is allegedly serving as the Covered Individual's Appeal representative, but the Contractor has still not received in writing the Authorized Appeal Representative form.

The Contractor shall not take punitive action against Providers who request an expedited resolution, or who support a Covered Individual's Internal Appeal.

If the Contractor denies a Covered Individual's request for an expedited resolution of an Internal Appeal, the Contractor shall:

Transfer the Internal Appeal to the timeframe for standard resolution in subsection **4.a**, above; and

Make reasonable efforts to give the Covered Individual and Appeal representative prompt oral notice of the denial, and follow up within two calendar days with a written notice. Such notice shall include the Covered Individual's right to file a Grievance.

The Contractor shall not deny a Provider's request (on a Covered Individual's behalf) that an Internal Appeal be expedited unless the Contractor determines that the Provider's request is unrelated to the Covered Individual's health condition.

Board of Hearings

The Contractor shall:

Require Covered Individuals and their Appeal representatives to exhaust the Contractor's Internal Appeals process before filing an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if either of the following conditions is met:

The Contractor has issued a decision following the second-level review of the Adverse Action; or

The Contractor has issued a decision following the first-level review of the Adverse Action and the Covered Individual has waived a second-level review of the Adverse Action;

Include with any notice following the resolution of a first- or second-level standard Internal Appeal or an expedited Internal Appeal any and all instructive materials and forms provided to the Contractor by EOHHS that are required for the Covered Individual to request a BOH Appeal; and

Notify Covered Individuals that:

Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services; and

It is the Covered Individual's or the Appeal representative's responsibility to submit any request for a BOH Appeal to the BOH and to ensure that the BOH receives the request within the following time limits, as specified in 130 CMR 610.015(B)(7):

For BOH Appeals of a standard Internal Appeal resolved by the Contractor within the timeframes specified in subsection **4.a**, 30 calendar days after the notice following the Final Internal Appeal, as specified in **Section 7.6.B.h**;

For BOH Appeals of a standard Internal Appeal resolved by the Contractor within the timeframes specified in subsection **4.a**, in which the Covered Individual wants to continue receiving the services that are the subject of the BOH Appeal, 10 calendar days after the notice following the Final Internal Appeal, as specified in **Section 7.6.B.h**;

For BOH Appeals of an expedited Internal Appeal resolved by the Contractor within the timeframe specified in subsection **4.d**, 20 calendar days after the notice following the Final Internal Appeal, as specified in **Section 7.6.4.h** or within 30 calendar days in which case the BOH Appeal will be treated as a non-expedited (i.e., standard) BOH Appeal Request;

For BOH Appeals of a standard Internal Appeal not resolved by the Contractor within the timeframe specified in subsection **4.a**, 30 calendar days from the date on which that timeframe expired; and

For BOH Appeals of an expedited Internal Appeal not resolved by the Contractor within the timeframe specified in subsection **4.d**, 20 calendar days from the date on which that timeframe expired.

Be a party to the BOH Appeal, along with the Covered Individual and his or her representative or the representative of a deceased Covered Individual's estate.

Additional Requirements

The Contractor shall:

For all Final Internal Appeal decisions upholding an Adverse Action, in whole or in part, provide EOHHS a copy of the decision sent to the Covered Individual and Appeal representative within one business day of issuing the decision. This shall include letters that are sent when the Contractor fails to act within the time frames for reviewing Internal Appeals, and letters sent issuing a decision, including all upheld First Level appeals that the Contractor knows or reasonably believes will be appealed at the Board of Hearings. The Contractor shall provide EOHHS with all necessary information to assist EOHHS's review of the Contractor's determination. For decisions involving Behavioral Health Services, EOHHS will consult with the Deputy Commissioner of the Department of Mental Health in its review of the Contractor's decision;

Upon learning of a hearing scheduled on a BOH Appeal concerning such a Final Internal Appeal, notify EOHHS immediately and include the names of the Contractor's clinical and other staff who will be attending the BOH hearing;

Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS's interpretation of any statute, regulation, and contractual provisions that relates to the decision;

Submit all applicable documentation to the BOH, EOHHS, the Covered Individual and the designated Appeal representative, if any, within five business days prior to the date of the hearing, or if the BOH Appeal is expedited, within one business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, a copy of the notice of Adverse Action, any documents relied upon by the Contractor in rendering the decision resolving the Internal Appeal, and any and all documents that will be relied upon at hearing;

Make best efforts to ensure that a Provider, acting as an Appeal representative, submits all applicable documentation to the BOH, the Covered Individual and the Contractor within five business days prior to the date of the hearing, or if the BOH Appeal is expedited, within one business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, any and all documents that will be relied upon at the hearing;

Comply with and implement the decisions of the BOH;

In the event that the Covered Individual appeals a decision of the BOH, comply with and implement the decisions of any court of competent jurisdiction; and

Designate an Appeals Coordinator to act as a liaison between EOHHS and the BOH to:

Determine whether each Covered Individual who requests a BOH Appeal has exhausted the Contractor's Internal Appeals process, in accordance with **Section 7.6.C.1**;

If requested by the Covered Individual, assist the Covered Individual with completing a request for a BOH Appeal;

Receive notice from the BOH that an Covered Individual has requested a BOH Appeal, immediately notify EOHHS, and track the status of all pending BOH Appeals;

Ensure that Continuing Services are provided when informed by the BOH that a request for a BOH Appeal was timely received, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Service;

Instruct Covered Individuals for whom an Adjustment has been made about the process of informing the BOH in writing of all Adjustments and, upon request, assist the Covered Individual with this requirement, as needed;

Ensure that the case folder and/or pertinent data screens are physically present at each hearing;

Ensure that appropriate Contractor staff attend BOH hearings;

Coordinate with BOH requests to reschedule hearings and ensure that the Contractor only requests that hearings be rescheduled for good cause;

Upon notification by BOH of a decision, notify EOHHS immediately;

Ensure that the Contractor implements BOH decisions upon receipt;

Report to EOHHS within 30 calendar days of receipt of the BOH decision that such decision was implemented;

Coordinate with the BOH, as directed by EOHHS; and

Ensure that appropriate Contractor staff attend BOH Appeals training sessions organized by EOHHS.

Continuing Services

The Contractor shall:

Comply with the provisions of 42 CFR 438.420 and, in addition, provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service;

Provide Continuing Services until one of the following occurs:

The Covered Individual withdraws the Internal Appeal or BOH Appeal; and

The BOH issues a decision adverse to the Covered Individual;

If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services that were not furnished while the Internal Appeal or BOH Appeal were pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Covered Individual's health condition requires; and

If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services and the Covered Individual received Continuing Services while the Internal Appeal or BOH Appeal were pending, the Contractor shall pay for such services.

Reporting

The Contractor shall submit to EOHHS all required reports related to Covered Individual, Provider and PCC services, as described in this **Section 7** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

QUALITY MANAGEMENT (QM)

Overview

The Contractor shall implement a comprehensive Quality Management (QM) program that includes ongoing quality assessment and performance improvement of all areas of the Contractor's responsibility under this Contract.

The QM program shall:

- Assess the quality and appropriateness of care and services furnished to all Covered Individuals, and to Enrollees with special health care needs;
- focus on improving the Covered Individual's health status through the delivery of high-quality and cost-effective care, and by the provision of programmatic supports that foster a high level of communication and cooperation among medical and Behavioral Health care providers, with regard to the Enrollees they are both serving;
- incorporate the principles of continuous quality improvement into all aspects of the operation of the Contract;
- be based upon robust data collection, accurate measurement, and data analysis that enhance Behavioral Health service delivery; the integration of care delivered by medical and Behavioral Health care providers; and Covered Individual health outcomes;
- include effective assessment of healthcare disparities and strategies to identify and address variations related to health care access and health outcomes; and
- include activities, resources and strategies that support Covered Individuals through Wellness and preventive health programs.

QM Program, Philosophy and Structure

The Contractor shall implement by the Service Start Date and maintain throughout the Contract a comprehensive QM program based on a written QM philosophy that is consistent with EOHHS priorities and goals**.**

Organizational Structure

The QM program shall be supported by an organizational structure that:

Is organization-wide, disseminated to, and understood by all Contractor employees;

Delineates clear lines of accountability for Quality Management within the organization;

Corresponds and complies with National Committee on Quality Assurance (NCQA) accreditation requirements;

Provides for an organizational Quality Council that is responsible for overseeing the QM activities throughout the organization and invites participation by EOHHS and DMH;

Includes written standard operating policies and procedures;

Includes a set of clearly defined qualifications, functions, roles and responsibilities for QM staff, including physicians, other clinicians and non-clinicians; and

Provisions for inclusion of Covered Individuals and their families in Quality Improvement (QI) activities.

Data Management

The Contractor's QM program shall be informed by consistent utilization and analysis of data, incorporating at least the following elements:

A process for collecting, analyzing and managing with data to improve Covered Individuals' health outcomes;

A process for tracking to resolution areas targeted for QI as identified by the Contractor, EOHHS or CMS;

Using multiple data sources and drawing conclusions based on data to drive system improvement through evidence-based practices, Practice Guidelines, and other data-driven clinical initiatives.

NCQA Accreditation

The Contractor must either be:

NCQA-accredited as an Health Plan/MCO or as a MBHO; or

apply and be accredited by NCQA as an Health Plan/MCO or a MBHO within the first year of the Contract.

Once accredited, the Contractor shall maintain accreditation pursuant to the requirements of NCQA.

QM Plan for Behavioral Health Management

The Contractor shall create on an annual basis, submit for EOHHS review and approval by January 31st of each Contract Year, and implement a single, comprehensive Quality Management plan that defines the QM program, details the Contractor's quality activities and provides for self-assessment of the Contractor's responsibilities under the Contract.

The QM plan for the first year of the Contract shall focus on the establishment of baselines and benchmarks for use in setting and assessing health improvement targets and quality improvement goals in subsequent years of the Contract.

The QM plan shall include activities, measures and performance improvement projects that are specifically relevant to each of the core activities designated within the Interdepartmental Service Agreement between DMH and EOHHS (ESP programs, MCPAP, and Forensic Evaluation program).

The QM plan shall describe planned improvement activities related to:

The Contractor's management of the BH services provided to Covered Individuals;

The Contractor's Management Support Services for the PCC Plan;

The Contractor's efforts to improve care integration across medical and Behavioral Health care services; and

The Contractor's Care Management Program.

Each year's proposed QM plan shall be informed by an assessment of prior years' activities and results through an annual retrospective report, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year, beginning with January 2013. The annual QM plan shall include but not be limited to:

Monitoring of the following performance indicators, at a minimum, and others as directed by EOHHS. If the results of the performance indicator(s) meet or exceed the benchmark, the Contractor shall continue to monitor the indicator(s); if the results of the performance indicator(s) fall below the benchmark, the Contractor shall implement a Quality Improvement Program (QIP) as directed by EOHHS. Performance Indicators shall, at a minimum:

Assess whether qualified and clinically appropriate Network Providers are available to provide BH Covered Services, and the degree to which the Provider Network met the needs of Covered Individuals for:

access within the access standards required by the Contract;

access within different geographic areas across the Commonwealth;

access to individuals with physical disabilities;

ability to communicate, either directly or through a skilled interpreter, with Covered Individual in his/her primary language; and

ability to address Covered Individuals' health disparity needs.

Assess Network Providers' success at communicating with Primary Care Practitioners, when appropriate.

Assess the development of the Behavioral Health service delivery system, including overuse, underuse and misuse of services; special measures shall be developed and implemented to highlight Provider best practices.

Assess and measure of utilization reviewers' consistency in applying Medical Necessity criteria in UM activities and in the medical record (chart) review process.

Assess and summarize critical incidents reported by Network and non-Network Providers, including actions taken in response.

Assess the subjects and outcomes of Appeals, Grievances and complaints, including timeframes required to reach resolution, and opportunities for improvement.

Assess Covered Individual, Network Provider and PCC satisfaction through administration of satisfaction surveys.

Timelines, objectives and goals for improvement projects and activities, including clinical and non-clinical activities as well as those BH improvement projects generated by the quality improvement (QI) goals as required by EOHHS. The projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Covered Individual, Network Provider and PCC satisfaction. The performance improvement projects must involve the following:

measurement of performance using objective indicators of quality;

implementation of system interventions to achieve improvement in quality;

evaluation of the effectiveness of the interventions; and

planning and initiation of activities for increasing or sustaining improvement.

The Contractor must complete each project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. The Contractor must report and present the status and results of each project to EOHHS at least twice a year, and as requested.

Analysis of the effectiveness of treatment services, employing standard measures of symptom reduction/management as well as measures of functional status and recovery. The Contractor shall recommend to EOHHS an approach to meet this requirement, including the assessment instrument, or scale, to be used and the methodology for its application. EOHHS reserves the right to approve or specify the instrument(s) and analysis methodology to be used.

Administration no less often than biennially of satisfaction surveys to Covered Individuals (see **Section 8.4.C**).

Administration no less often than biennially of Network Provider satisfaction surveys, with results stratified by provider type and specialty.

Administration biennially of PCC satisfaction surveys with results stratified by provider type and specialty.

Quality Management Plan for PCC Plan Management Support Services

The Contractor shall create and implement a single, comprehensive Quality Management plan, containing the same elements as described in **Section 8.2**, that reflects the Contractor's organizational QM philosophy and structure and includes PCC Plan Management Support Services-related activities. Such QM plan shall be submitted to EOHHS for review and approval by January 31st of each Contract Year. This component of the QM plan shall describe planned improvement projects and activities, including but not limited to:

Timelines, objectives and goals for the planned improvement projects and activities, including clinical and non-clinical initiatives;

A process for monitoring data for, and tracking to resolution, areas targeted for quality improvement (QI) as identified by the Contractor or EOHHS;

A process for comparing QI project results against established goals;

Plans for coordinating medical and Behavioral Health care services;

A process for monitoring PCCs' ability to manage the health care needs of culturally diverse PCC Plan Enrollees;

A process to evaluate annually the effectiveness of QM plan activities and, based on the results, to identify and implement improvement activities;

An annual retrospective QM activities report based on the previous year's QM plan, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year, beginning with January 2013.

Satisfaction Measurements

Consistent with NCQA accreditation requirements, the Contractor shall conduct assessments of Network Provider, PCC and Covered Individual satisfaction.

Network Provider Satisfaction

The Contractor shall survey Network Providers biennially, starting with Contract Year Two, using a written survey instrument approved by EOHHS, to assess Network Provider satisfaction with the Contractor's administration and management of the BHP and the Care Management Program. The Contractor shall analyze the results of the survey and provide EOHHS with results stratified by Provider type and specialty, by separate program components, and in aggregate.

PCC Provider Satisfaction

The Contractor shall survey PCCs biennially, starting with Contract Year Two, using a written survey instrument approved by EOHHS, to assess PCC satisfaction with the Contractor's administration and management of the BHP, PCC Plan Management Support

Services, and the Care Management Program. The Contractor shall analyze the results of the survey and provide EOHHS with results stratified by Provider type and specialty.

Covered Individual Satisfaction

At the direction of EOHHS, and using one or more external organizations with appropriate experience, the Contractor shall conduct satisfaction surveys of Covered Individuals regarding the requirements of this Contract, as follows. The Contractor shall:

Propose to EOHHS an approach to meet this requirement, including the experience of care survey to be used, and the methodology for its application. EOHHS reserves the right to approve or specify the instrument(s) and analysis methodology to be used;

Ensure that the surveying organization has appropriate experience, conducts surveys by mail or by telephonic and/or site-based interviewing, and includes a valid sample of Covered Individuals; and

Share survey results and analysis with Providers and EOHHS, in accordance with timelines as directed by EOHHS, and utilize the survey results as part of Network Management, Quality Management and program development. The Contractor shall provide such reports to EOHHS upon request.

Upon request by the Member, share the results of the Member's Enrollee survey.

Quality Improvement Projects

The Contractor shall annually develop and propose to EOHHS quality improvement projects (QIPs) to be incorporated into the Contract each year.

Development of QIPs

In conjunction with the development of the annual Quality Management plan each Contract Year, the Contractor shall identify and propose for EOHHS's review and approval a minimum of five annual contractual quality improvement projects. The Contractor shall design Quality Improvement Projects (QIPs) to achieve significant improvement in clinical care and non-clinical care areas that have a favorable effect on health outcomes and Covered Individual satisfaction. The Contractor shall design QIPs as ongoing interventions, sustained over time. The Contractor shall target QIPS to areas that present significant opportunities for performance improvement and meet the following description:

The QIPs shall be based on the Contractor's actual experience serving Covered Individuals, the findings of the assessments required in **Section 8.2.D**, and the performance indicators required in **Section 8.6**. The Contractor also may identify other areas, such as those internal to the Contractor's operation, for inclusion in quality improvement projects.

Data sources for the design of the QIP may include without limitation:

critical incident (Reportable Adverse Incident) reports;

continuing care after discharge from one Level of Care to another, community tenure, and recidivism rates;

Grievances and Internal Appeals and other feedback from Covered Individuals;

Provider concerns;

medical record reviews;

Provider waiting lists;

Covered Individual and Provider satisfaction/experience surveys;

direction from EOHHS and DMH related to agencies' goals;

data related to PCC Plan Management Support Services activities;

the Care Management program; and

data relative to the Contractor operations, such as Claims processing time frames and telephone response time.

The proposed QIPs may include administrative service, quality, and program development goals, although no more than two projects may address administrative services.

Each proposed QIP shall incorporate a project statement that includes highly specified and measurable goals and objectives, methodology, as well as detailed metric calculation specifications.

For each QIP, the Contractor shall develop a work plan for completion of the project including time frames by which the Contractor must demonstrate that the goals of the project have been achieved.

At least two of the five QIPs the Contractor proposes shall be as described in **Section 8.2.D.2** that satisfy the requirements of 42 CFR 438.240(b) and (d). EOHHS's External Quality Review (EQR) vendor shall validate the Contractor's performance of these quality improvement projects. Current listing of BH priority area standard goals including performance measures and quality improvement project initiatives are in **Appendix G**.

Should EOHHS and Contractor be unable to reach agreement on the improvement projects and/or the measures, EOHHS shall establish the improvement projects and/or measures.

Management of the QIPs

The Contractor shall designate relevant QM staff to meet with EOHHS twice a year to review operational issues, milestones and initiatives, as well as progress toward the QIPs, in Contract status meetings.

The Contractor shall evaluate the outcome of the QIPs and present its findings to EOHHS in the forms and time frames agreed to by EOHHS.

If EOHHS determines that the Contractor is not in compliance with the requirements for proposed annual QIPs, the Contractor shall prepare and submit a corrective action plan to EOHHS for review and approval.

Pay for Performance (P4P)

Development of Behavioral Health Pay for Performance Measures

The Contractor shall be eligible for P4P based on exceptional performance based on Contractor results on a select subset of measures that are reliable indicators of quality improvement.

Measures shall be standardized and nationally accepted, except as described in subsection **B.2** below.

EOHHS may consider including non-nationally-accepted measures where such measures are not available to assess Contractor performance on a matter of particular importance to EOHHS.

Measures may change on an annual basis, at the discretion of EOHHS. For Contract Year One, EOHHS has selected the following four measures eligible for P4P:

HEDIS – IET – initiation and engagement of alcohol and other drug dependence treatment;

HEDIS – FUH – Follow-up after hospitalization for mental illness;

HEDIS – ADD – Follow-up for children prescribed ADHD medication;

Service Integration: Primary Care visits for DMH Clients.

Three of the four measures come from the HEDIS data set. The fourth measure focuses on improved health integration through improvements to the percentage of DMH Clients who receive annual Primary Care and appropriate follow-up visits. The Contractor shall work with EOHHS to define the measure to be utilized to measure service integration; provided, however, that EOHHS in its sole discretion shall determine the specific measures.

Behavioral Health Pay for Performance Methodology

Incentive Structure

The P4P incentive structure shall:

Allow for a maximum incentive value for each P4P measure to be designated by EOHHS that corresponds proportionally to the size of the population identified for each P4P measure as detailed above.

Allow for partial P4P to the Contractor for demonstrating incremental improvements in performance, where those improvements exceed certain standards set by EOHHS.

Provide full payment to the Contractor for attaining the highest designated standard of performance as established by EOHHS.

Baseline Measurement

During the Contract Year One, the Contractor shall utilize a baseline for measures established by EOHHS for the PCC Plan in the HEDIS reporting year prior to the Service Start Date. In future Contract years, the Contractor shall be responsible to establish, with EOHHS approval, baseline measurement rates from which to assess performance.

Measurement must follow standard measurement protocols for HEDIS. For example, one full calendar year of Encounter data may be required to produce and establish a HEDIS baseline measurement.

Beginning in Contract Year Two, the measurement methodology may, at the discretion of EOHHS, include all Covered Individuals, not only Enrollees.

Tiers of Measurement

The Contractor shall work with EOHHS to develop Tiers of measurement and performance targets for each measure selected as eligible for P4P. Each performance measure shall have three Tiers of measurement:

Attainment Threshold: represents a minimum level of acceptable performance based on current PCC Plan performance or national Medicaid averages, whichever is higher, that must be met in order for any P4P payment to be made;

Improvement Range(s): representing the minimum and incremental levels of improvement that are prerequisites to the Contractor becoming eligible for partial payments for performance; and

Benchmark: representing excellent performance and full payment for performance.

Data and Measurement Integrity

The Contractor shall be responsible for the integrity of the performance measurement data sets for all required measures, including any subsets of select measures included in P4P.

Contractor shall be responsible for the accuracy of the calculations and measurement.

Contractor shall make available to EOHHS and its designees, including auditors and the EQRO, all performance measurement data sets, including any subsets of select measures included in pay for performance, and associated programming, calculation methodologies and related materials.

Care Management Performance Incentives

Care Management Performance Incentive Arrangements shall be based on Contractor performance in engaging Providers and program Participants and improving outcomes for such Participants.

Each Contract Year the Contractor shall propose, subject to EOHHS approval, the minimum Engagement Targets by Tier and the PPPM rate per Tier.

The remaining Care Management Performance Incentive Arrangements may be earned based on Contractor performance on a designated set of outcomes measures to be proposed by the Contractor for EOHHS review and approval. There shall be no fewer than four outcome measures in Contract Year One.

The Care Management performance measurement areas for Year One are included in **Appendix G**.

The Contractor shall develop for EOHHS review and approval a Pay-for-Performance Incentive arrangement to improve access to and quality of outpatient Behavioral Health providers. This Performance Incentive shall be completed no later than June 30, 2013.

Other Measures of Quality

Overview

In addition to the Performance Incentive measures described in **Section 8.6**, the Contractor shall conduct ongoing measurement based on a set of quality indicators established by EOHHS or proposed by the Contractor and approved by EOHHS. Other measurement categories include:

Quality indicators that are to be monitored relative to established contract standards and for which the Contractor may incur sanctions or penalties, as determined by EOHHS, if the Contractor's performance is below the standard;

Quality indicators that may be applicable, to Enrollees and to Covered Individuals, and for which the measurement design and measurement specifications may be proposed by the Contractor and approved by EOHHS; and

Quality indicators assessed through standard reporting requirements.

Measures of quality shall be reassessed annually and may be prioritized, modified, substituted or deleted throughout the Contract term.

Pursuant to 42 CFR 438.6(f)(2)(ii), the Contractor shall comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by EOHHS.

Development of Measures

Measures will be developed based on the following criteria:

Measures should be relevant, and should assess:

Processes known to be linked to improved health outcomes; and

Health outcomes or proxies for improved health outcomes.

Measures should be, to the extent possible, based upon industry standards for the measure specifications; and

Measures should be based on data that is feasible to collect; and shall include clear, detailed specifications.

QM Staffing and Staff Training

The Contractor shall:

Employ appropriately qualified staff experienced in QM in sufficient numbers to satisfy all QM responsibilities. Staff shall include the following positions, unless otherwise approved by EOHHS:

QM Director – a senior manager designated as key personnel; responsible for overseeing all QM activities related to the Contract, and accountable to the Contractor's appropriate clinical leadership, such as an Associate Medical Director with Quality Management experience, for the successful performance and execution of such activities; and

The Contractor's **Director of Quality** shall be dedicated solely to the Contract, with demonstrated expertise in quality improvement processes, and shall develop and coordinate all quality improvement program-related activities, including but not limited to staff training in quality improvement processes. Quality improvement objectives shall meet the health care needs of Enrollees, and address integration of care.

QM Analyst(s) – dedicated solely to the Contract and its QM activities, responsible for MIS-related functions such as report production, analysis, and methodological problem-solving and data interpretation.

Each Contract Year, determine the need for training staff in relevant aspects of Quality Management, practice management, or other related skills, and develop and provide such training as necessary.

Ensure that Contractor QM staff collaborate with all applicable units within the Contractor's organization to provide Contract services in a consistent, coordinated manner.

Quality Management – Network Providers

Quality Management Activities

The Contractor shall:

Develop and implement by a date agreed to by EOHHS a work plan for QM activities with Network Providers that measures, among other things, Covered Individuals' functional status and recovery from mental illness and substance use disorders and ensures that:

community-based Network Providers utilize standardized assessment tools approved by the Contractor to assess treatment outcomes, and that data is being utilized in those settings as needed for practice improvement activities;

acute services Network Providers utilize standardized assessment tools approved by the Contractor to inform discharge planning; and

the results of the assessment and discharge plans are forwarded whenever a Covered Individual proceeds to another Level of Care, and to PCCs, as applicable.

Develop and implement a medical record (chart) review process for:

Monitoring provider compliance with written policies and procedures, program specifications, Medical Necessity criteria and billing practices,

Monitoring the quality of services provided, including adherence/fidelity to any evidence-based practices; and

Documenting remedial steps undertaken pursuant to QI corrective action plans for Network Providers.

Ensure that Network Providers adopt continuous quality improvement practices.

Develop and implement:

A process for monitoring Network Providers' compliance with the Contractor's written policies and procedures, program specifications, and appropriateness of care;

A quality assurance process to monitor variation in Provider Network practice patterns, and the identification of outliers and promote care consistent with evidence-based clinical Practice Guidelines;

A process to monitor Providers' safe and appropriate use of restraint and seclusion techniques and its implementation of plans to reduce the use of such techniques; and

A process to use issues identified through the Reportable Adverse Incident reporting process to guide quality and Network management strategies.

Coordination of Network Provider and PCC Profiling and Reporting

The Contractor shall coordinate its profiling activities for Network Provider and PCC Plan MSS programs as described in **Section 5** to ensure optimal integration of delivery of BH Covered Services to Covered Individuals and Enrollees. Findings from each program shall inform the other program over the course of the Contract. Specifically, the Contractor shall:

Develop and submit to EOHHS for approval a plan to ensure that both medical and BH issues are addressed in both the PCC Plan MSS and the Network Provider profiling. The plan must include:

the measures, specifications and data sources the Contractor will use; and

timelines for development and implementation of coordinated measures.

Work collaboratively with EOHHS to continually enhance the Network Provider and PCC Plan MSS profiling programs to improve health outcomes for Covered Individuals and Enrollees.

Forums and Councils

Provider and PCC Quality Forums

The Contractor shall:

Annually organize and conduct at least four quality forums, as follows:

The quality forums shall be held through a webinar at a variety of times convenient to PCCs, Network Providers and other providers as directed by EOHHS. Some or all of the forums may also be held at locations throughout the state, in comfortable environments that encourage PCCs, Network Providers and other providers as appropriate to attend, and including refreshments (food and non-alcoholic beverages) as part of the event.

The quality forums shall be offered on topics that primarily focus on EOHHS goals, quality improvement, increased coordination and collaboration of medical and Behavioral Health care services, or improved service delivery and health outcomes for Covered Individuals.

By September 1 of each year, the Contractor shall submit to EOHHS for review and approval a proposal for the quality forum topics for the year. EOHHS may also require the Contractor to conduct forums on topics of EOHHS's choosing.

The Contractor shall develop the content of each quality forum in collaboration with EOHHS and key stakeholders.

Ensure that only those individuals on the Contractor's staff who are necessary to ensure an effective quality forum attend each forum.

Implement a mechanism for attendees and the Contractor to evaluate the quality forums and identify areas for improvement and, with EOHHS's approval, incorporate such improvements into future quality forums.

Obtain the required approval to offer and grant continuing medical education, risk management, and continuing education units to participants.

Provide a summary report on each series of quality forums described in this **Section 8.11**. The report shall include, at a minimum, information on the number and type of attendees (profession and practice name), the location, the presentation topic and responses from attendees regarding the quality of the program presented. The report shall be submitted within 30 days after the last session of a forum series.

Advisory Committees and Councils

The Contractor shall establish the following advisory councils for the exchange of stakeholder ideas related to this Contract, discussion of relevant topics, and the solicitation of advice, recommendations or concerns. The structure and purpose of the committees and councils must be consistent with NCQA protocols. The goal of these committees and councils shall be to foster improved quality, integrated care and Covered Individual, Provider and PCC satisfaction. The committees and councils shall follow standard rules of order and maintain a written record or minutes of each meeting. All committees and councils must meet at least once during the first six months of Contract Year One, and on a regular schedule thereafter.

The advisory committees and councils described in this section shall not be the only venue for soliciting input from stakeholders.

PCC Clinical Advisory Committee

The Contractor shall establish and facilitate a PCC Clinical Advisory Committee whose main objective is to support and promote improvement in the quality of clinical services provided to Enrollees.

The meetings shall be held at least three times a year and shall include refreshments (food and non-alcoholic beverages) as part of the event.

The membership of the PCC Clinical Advisory Committee shall be subject to EOHHS's approval, and shall consist of:

from eight to 14 PCCs who represent different types of PCC practices, different PCC specialty types, and diverse geographic areas of the Commonwealth;

at least one Network Provider; and

other MassHealth providers acting as specialists, if directed or approved by EOHHS.

BH Clinical Advisory Committee

The Contractor shall establish and facilitate a BH Clinical Advisory Committee whose main objective is to support and promote improvement in the quality of BH Covered Services provided to Covered Individuals, including the integration of medical and Behavioral Health services to the benefit of the Covered Individual.

The meetings shall be held at least three times a year and shall include refreshments (food and non-alcoholic beverages) as part of the event.

The membership of the PCC Clinical Advisory Committee shall be subject to EOHHS's approval, and shall consist of:

from eight to 14 Network Providers who represent different types of Network Providers (e.g., mental health clinics, hospitals, individual practitioners) and different BH specialties from diverse geographic areas of the Commonwealth; and

at least one PCC.

EOHHS may also recommend to the Contractor Network Providers to be invited to serve on the committee. EOHHS, DMH, and other state agencies and major stakeholders identified by EOHHS shall be invited to participate in the committee's meetings.

The activities of the BH Clinical Advisory Committee shall include:

establishing bylaws that include designating a term of duty for committee members;

meeting jointly with the PCC Clinical Advisory Committee (see **Section 8.11.B.1**, above), at least one time per Contract Year; and

developing agendas that promote and support the QM activities of the BHP, including the integration of medical and Behavioral Health care services to the benefit of Covered Individuals and Enrollees.

Enrollee and Family Advisory Councils

The Contractor must include Enrollees and their families in QM activities and document their participation in Enrollee and family advisory councils.

Other Advisory Committees

As directed by EOHHS during the term of the Contract, the Contractor shall facilitate and convene additional advisory committees, which EOHHS shall chair.

HEDIS and Other QM Data Activity

QM Data Collection

The Contractor shall collect and provide to EOHHS:

Data identified by EOHHS in a format specified by EOHHS in order that EOHHS can complete the Behavioral Health-related Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are selected annually by EOHHS and validated by its EQR Contractor pursuant to 42 CFR 438.358(b)(1);

Encounter data; and

Other QM data sets, including data from medical record reviews, as directed by EOHHS during the term of the Contract.

Calculation of HEDIS Measures

The Contractor shall calculate selected BH and non-BH HEDIS measures as directed by EOHHS. The Contractor shall ensure the accuracy of all HEDIS measurement calculations.

Practice Guidelines

Practice Guidelines Endorsed by EOHHS and its Agencies

The Contractor shall:

Adopt any practice guidelines established or endorsed by EOHHS and its agencies, including DMH; and

Disseminate such guidelines to all affected Network Providers, PCCs, and other providers as appropriate, as well as to Covered Individuals upon request. Such dissemination may include posting the guidelines on the Contractor's website.

Disseminate evidence-based clinical practice guidelines and process improvement methodologies to Network Providers and PCCs, as appropriate.

Practice Guidelines Established by the Contractor

The Contractor may propose Practice Guidelines to EOHHS for prior approval, as the Contractor deems appropriate. Such guidelines must:

be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

consider the unique Behavioral Health and medical needs of Covered Individuals; and

be developed in conjunction with Covered Individuals, their families, Network Providers, PCCs, and clinical subject-matter experts within EOHHS agencies.

The Contractor shall not adopt such Practice Guidelines unless EOHHS approves them. If EOHHS approves the guidelines, the Contractor shall:

review and update the Practice Guidelines periodically, as appropriate, and submit any modifications to EOHHS for approval;

disseminate the Practice Guidelines to all affected Network Providers, PCCs, and other providers as appropriate, as well as to Covered Individuals upon request. Such dissemination may include posting the guidelines on the Contractor's website;

provide training, education, and support for their implementation; and

ensure that decisions regarding Utilization Management, Covered Individual education, coverage of services, and other areas to which such Practice Guidelines apply are consistent with the guidelines.

External Quality Review (EQR) Activities

The Contractor shall take all measures necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS (EQR Contractor) to conduct External Quality Review Activities in accordance with 42 CFR 438.358, as described below.

EQR activities shall include, but are not necessarily limited to:

Annually validating performance improvement projects required by EOHHS;

Annually validating performance measures reported to EOHHS, as directed or calculated by EOHHS; and

At least once every three years, reviewing compliance with activities mandated by 42 CFR Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Covered Individuals.

EQR measures to support the EQR Contractor in conducting EQR Activities shall include, but are not necessarily limited to:

Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:

Oversee and be accountable for compliance with all aspects of the EQR Activity;

Coordinate with staff responsible for aspect

of the EQR Activity and ensure that staff respond to requests by the EQR Contractor in a timely manner;

Serve as liaison to the EQR Contractor and EOHHS staff and answer questions or coordinate responses to questions from the EQR Contractor and EOHHS staff; and

Ensure timely access to information systems, data and other resources, as necessary for the EQR Contractor to perform the EQR Activity and as requested by the EQR Contractor or EOHHS.

Maintaining data and other documentation necessary to validate performance of EQR Activities. The Contractor shall maintain such documentation for a minimum of seven years.

Reviewing the EQR Contractor's draft EQR Activities report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQR Contractor or EOHHS.

Implementing actions, as directed by EOHHS, to address recommendations for quality improvement made by the EQR Contractor and sharing outcomes and results of such activities with the EQR Contractor and EOHHS in subsequent years.

The Primary Care Payment Reform Initiative

Program Overview

The Primary Care Payment Reform Initiative (PCPR) is MassHealth's test of an alternative provider payment methodology that supports a Patient-Centered Medical Home model with a focus on Behavioral Health integration. The PCPR payment model consists of three parts: a monthly prospective capitation payment for Primary Care services and certain outpatient Behavioral Health Services, if selected by the PCPR Provider; a quality incentive bonus; and a shared savings payment based on total spend for services not included in the monthly capitation payment.
Certain PCCs applied and have been selected as PCPR Providers and contracted with EOHHS to participate in the program in December 2013. PCPR Providers chose the level at which they would participate in PCPR based on the PCPR Covered Services they would provide. Tier 1 PCPR Covered Services Providers receive a capitation payment only for primary care medical services. Tier 2 PCPR Covered Services Providers receive a capitation payment for primary care medical services as well as certain outpatient behavioral health services. Tier 3 PCPR Covered Services Providers receive a capitation payment for primary care medical services as well as a more expansive list of outpatient behavioral health services.

Contractor Responsibilities

In support of the PCPR initiative, the Contractor shall pay PCPR Providers as described herein, monitor the progress of PCPR Providers, meet with the EOHHS as frequently as EOHHS determines necessary, and any other responsibilities described herein for the ongoing implementation of the PCPR initiative.

Reporting

The Contractor shall submit to EOHHS all required reports related to Quality Management, as described in this **Section 8** or **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

INFORMATION SYSTEMS AND TECHNICAL SPECIFICATIONS

General Information Systems Requirements

General

The Contractor shall:

Maintain information systems (Information Systems) that will enable the Contractor to meet all of the EOHHS's requirements as outlined in this Contract. The Contractor's Information Systems shall be able to support current EOHHS requirements, and any future IT architecture or program changes.

Accept all Contract-related files and data delivered by EOHHS, in the format specified by EOHHS.

Ensure a secure, HIPAA-compliant exchange of information on Covered Individuals and Uninsured Individuals and persons with Medicare only, as applicable, between the Contractor and EOHHS and any other entity EOHHS deems appropriate. Such files shall be transmitted to EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS.

Develop and maintain a website that is accurate, up-to-date, and designed in a way that enables Covered Individuals and Providers to quickly and easily locate all relevant information (see **Section 7.1.G**). The Contractor's website must be ADA-compliant and compliant with the online security protocols of the Public Company Accounting Reform and Investor Protection Act of 2002 (the so-called "Sarbanes-Oxley" law), as appropriate. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website(s).

Cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS.

Actively participate in any EOHHS Systems Workgroup or other workgroups, as directed by EOHHS. The workgroup shall meet in the location and on a schedule determined by EOHHS.

Retain online access to all EOHHS information systems as required by the Contract or directed by EOHHS, and ensure that such access is maintained for the duration of the Contract, unless otherwise directed by EOHHS.

Establish and maintain an Internet or future interchange connection with the Massachusetts Information Technology Division (ITD) and/or EOHHS to permit file transfers (e.g., eligibility updates) and interactive access by EOHHS to the Contractor's Information System, and ensure that such connection is maintained for the duration of the Contract, unless otherwise directed by EOHHS.

Provide all other automated tracking and processing systems needed to carry out the responsibilities of the Contract.

Provide and maintain all necessary functionality, hardware and software to meet industry standards, to include at least the following:

Standard office software (word processing, spreadsheets, databases, e-mail communication, etc.) and operating systems on desktop, compatible with EOHHS's systems and licensed for all staff users;

Internet connectivity and the appropriate internet capacity to support the Contract; and

Business Intelligence reporting capability that is compatible with EOHHS's systems.

Implement any changes, enhancements and updates to its Information System to allow the Contractor to perform its responsibilities under the Contract, including collaborating with EOHHS on any changes to EOHHS's systems that affect the Contractor's ability to perform its responsibilities under the Contract.

Work with EOHHS to test or evaluate new or enhanced system changes pertaining to the exchange of any electronic information, to ensure that such changes meet Contract specifications and are compatible with other operating processes.

Take all steps necessary to ensure that the Contractor's Information Systems will be able to interface with and accommodate any new EOHHS IT projects that affect the Contractor.

Immediately report to EOHHS any telephone system, fax website, related software application or Information System problem(s) identified in the course of daily operations that prevent or impair the Contractor's performance of its Contract responsibilities.

Design Requirements

The Contractor shall:

Comply with EOHHS requirements, policies and standards in the design and maintenance of its Information Systems in order to successfully meet the requirements of this Contract.

Ensure that its Information Systems interface with and are compliant with EOHHS's MMIS, the EOHHS Virtual Gateway, and other EOHHS IT architecture that EOHHS identifies.

Have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files including HIPAA transaction files, as specified on the 820 Companion Guide, 834 Outbound Companion Guide available at:

http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/mmis-posc/hipaa-version-5010.html.

Interface files in the Contract include but are not limited to:

HIPAA 834 History Request File

HIPAA 834 Outbound Daily File

HIPAA 834 Outbound Full File

HIPAA 834 History Response

HIPAA 820

Have the ability to receive and analyze data from the EOHHS Data Warehouse regarding medical and pharmacy Claims, as provided by EOHHS.

Conform to HIPAA-compliant standards for data management and information exchange.

Implement controls to maintain information security and integrity.

Maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS. These processes may be reviewed by EOHHS upon request.

Collaborate with EOHHS to verify its compliance with Version 5010 standards during the readiness review period prior to the Service Start Date.

Use the Version 5010 standards for HIPAA electronic health care transactions, including claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions.

Implement Version 5010 standards and framework for the revised medical data code sets (ICD-10-CM and ICD-10-PCS), by October 1, 2014.

Ensure that an automated health information system (HIS) to support all of the Contractor's responsibilities under the Contract is operative as of the Service Start Date and remains operative for the duration of the Contract, unless otherwise directed or agreed to by EOHHS. The HIS must achieve the objectives of 42 CFR Part 438, Subpart D and shall collect, analyze, integrate and report data, including but not limited to information regarding:

Service authorizations;

Utilization;

Grievances, Internal Appeals, and BOH Appeals;

Provider information;

Services furnished to Covered Individuals through an Encounter data system, as specified in **Section 9.5**;

Covered Individual characteristics, including but not limited to race, ethnicity, spoken language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheelchair dependence, and characteristics gathered through Contractor contact with Covered Individuals, e.g., through the Care Management Program, Behavioral Health Clinical Assessments, or other reliable means;

Enrollee participation in the Care Management Program; and

Identification of Covered Individuals as belonging to any of the special populations or subgroups identified through provision of clinical services.

Ensure that data received from Providers is 99 percent complete and 95 percent accurate by:

Verifying the accuracy and timeliness of reported data;

Screening the data for completeness, logic and consistency;

Establishing a remediation process for data that is deemed inaccurate during verification and screening; and

Collecting service information in standardized formats to the extent feasible and appropriate.

Make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(3).

Utilize its HIS to pay Network Providers for BH Covered Services and ESP Services rendered to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only, in accordance with the Contractor's service authorization, Claims processing, enrollment and disenrollment procedures, and data handling and administrative billing requirements.

System Access Management and Information Accessibility Requirements

The Contractor shall make all Information Systems and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor's data and Information Systems.

The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

System Availability and Performance Requirements

The Contractor shall ensure that its Covered Individual and Provider web functions and phone-based functions are available to Covered Individuals and Providers 24 hours a day, seven days a week.

The Contractor shall draft an alternative plan that describes access to Covered Individual and Provider information in the event of Information System failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) (see **Section 13.36**) and shall be updated annually and submitted to EOHHS upon request. In the event of Information System failure or unavailability, the Contractor shall notify EOHHS upon discovery, and implement the COOP immediately.

The Contractor shall preserve the integrity of Covered Individual-sensitive data whether active or archived.

Virtual Gateway

If EOHHS directs the Contractor during the term of this Contract to access certain services through the Virtual Gateway, the Contractor shall:

Submit all specified information, including but not limited to invoices, Contract or other information to EOHHS through these web-based applications;

Comply with all applicable EOHHS policies and procedures related to such services;

Use all business services through the EOHHS Virtual Gateway, as required by EOHHS;

Take necessary steps to ensure that the Contractor and its subcontractors or affiliates have the ability to access and utilize all required web-based services; and

Execute and submit all required agreements, including subcontracts, agreements, memorandums of understanding, confidentiality and/or end user agreements in connection with obtaining necessary end user accounts for any Virtual Gateway business service.

Automated Service Authorization

The Contractor shall employ an automated service authorization system that supports the service authorization requirements and procedures in **Section 4.2** and provides for the documentation of at least the following information for each Covered Individual:

Identifying demographic information;

Identification of Provider delivering service, including his/her national provider identifier (NPI);

Diagnosis code(s);

Authorized service units.

Claims Processing

The Contractor shall ensure that its Claims processing system performs, at a minimum the following functions:

Maintains a unique Provider identification number for each Provider and utilizes the NPI for purposes of billing.

Accepts Claims submitted by Network Providers or their designated representative(s). The Contractor shall:

Accept national UB-04 and national CMS 1500 electronic formats;

Accept paper-based Claims using standardized forms.

Adjudicates Claims and issues payment for approved Claims once a week, at a minimum.

Adjudicates and issues payment for all Clean Claims within 30 days of receipt of the Clean Claim.

Provides policies and procedures that track all Claims from point of receipt to final disposition, in order to ensure that all invoices and electronic media Claims are processed to completion and have not been previously paid.

Creates payment and HIPAA 835 remittance advices for each Provider for Claims activities during a current cycle. The system specifications and file layout must:

Identify each Claim in a cycle and its status, including a description of all errors and denial reasons; and

Generate the remittance advices in electronic or paper format, as appropriate for each Provider.

Collects and maintains Network Provider financial data and issues state and federal income tax documents in accordance with state and federal law. This shall include, at a minimum, TIN/FEIN and NPI.

Maintains all Claims files and records in accordance with all applicable laws, and submits them to EOHHS, the Commonwealth or federal agencies, as needed and upon request.

Ensures that security controls are in accordance with current industry standards and relevant CMS policy.

Ensures confidentiality of all data in accordance with state and federal laws and regulations, including 42 CFR 431, Subpart F, implementing procedures to properly safeguard and dispose of data. (See also **Section 14.B.5**.)

Member Eligibility System Requirements

The Contractor shall create policies and procedures to ensure that its enrollment system performs, at a minimum, the following functions:

On each business day, obtains from EOHHS by electronic communications link and immediately updates its database with all information pertaining to all Covered Individual enrollments.

Uniquely identifies each Covered Individual, and includes in the Contractor's data system information provided by the EOHHS eligibility feed regarding the Covered Individual's state agency affiliations, PCC enrollment, PCC, and TPL status. This information must also be incorporated into the Contractor's clinical Information Systems. The Contractor must use the EOHHS-assigned MID as the Covered Individual identifying number.

On each business day receives and processes an electronic file of EOHHS's MID merges.

On each business day, receives from EOHHS by electronic communications link and processes information pertaining to all disenrollments.

Once a month receives and processes a copy of EOHHS's carrier file, including carrier codes, and uses this file to reconcile the Contractor's cost avoidance and recovery activities.

Once a month receives a list of EOHHS's PCCs and track the accuracy of information on PCCs if directed to do so by EOHHS.

Receives and processes on a quarterly basis, or as otherwise agreed to by EOHHS, a file containing a list of all Covered Individuals, by MID, Plan Type and effective dates, and uses this file to reconcile the Contractor's Covered Individual enrollment file with EOHHS data.

Encounter Data

Data Transfers

No later than the fifteenth day of each month, the Contractor shall provide EOHHS with the Encounter Data Set for the preceding month in a format consistent with that described in **Appendix D** and this section.

Encounter Data

The Contractor shall:

Ensure that its Information Systems generate and transmit Encounter data files according to the specifications outlined in **Appendix D** as updated from time to time. EOHHS may update or replace **Appendix D** without the need for a Contract amendment.

Maintain processes to ensure the validity, accuracy and completeness of the Encounter data in accordance with the standards specified in this **Section 9.5**.

Develop and maintain remediation process and key contacts for Encounter data that is deemed invalid.

Collect and maintain 100 percent Encounter data for all Behavioral Health Covered Services provided to Covered Individuals and Uninsured Individuals, including persons with Medicare only, receiving ESP Services through the Contractor, including from any subcapitated sources. Such data for Covered Individuals must be able to be linked to MassHealth eligibility data.

Participate in site visits and other reviews and assessments by EOHHS or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter data.

Upon request by EOHHS or its designee, provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually.

Produce Encounter data according to the specifications, format, and mode of transfer reasonably established by EOHHS or its designee in consultation with the Contractor. Such Encounter data shall include, but is not limited to, the data elements described in **Appendix D**.

Provide Encounter data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor.

Submit Encounter data that is, at a minimum, 99 percent complete and 95 percent accurate. To meet the completeness standard, all critical fields in the data must contain valid values. To meet the accuracy standard, the Contractor must have systems in place to monitor and audit Claims and identify errors. The Contractor must also correct and resubmit denied Encounters as necessary. The data shall be considered complete and accurate if the error rate in the initial submission is no more than 3 percent and the number of Encounters that need to be manually overridden is no more than 1 percent.

Ensure that all initial Behavioral Health Clinical Assessments are explicitly identified in the Encounter data submitted in accordance with this **Section 9.5.B**.

If EOHHS or the Contractor determines at any time that the Contractor's Encounter Data is not 99 percent complete and 95 percent accurate, the Contractor shall:

Notify EOHHS, prior to Encounter data submission, that the data is not complete or accurate.

Submit for EOHHS approval a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level, and a timeline for resolution of the issue. EOHHS shall establish the time frame

the Contractor to submit the corrective action plan, but in no event shall it be submitted later 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter data requirements.

Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS, which shall in no event be later than 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval.

Following the Contractor's implementation of the corrective action plan, the Contractor shall participate in a validation study to be performed by EOHHS or its designee, to assess whether the Encounter data is 99 percent complete and 95 percent accurate. The Contractor may be financially liable for such validation study.

Report as a voided Claim in the monthly Encounter data submission any Claims that the Contractor pays, and then later determines it should not have paid.

Eligibility Verification System (EVS)

The Contractor shall maintain access to EOHHS's computer network for online inquiry access to the Eligibility Verification System (EVS) and the Medicaid Management Information System (MMIS) databases for identification of Covered Individuals, their MassHealth eligibility, Managed Care enrollment status, and service restrictions.

Telephone System

Specifications

As of the Service Start Date the Contractor shall:

Maintain the telephone number (800-495-0086), with telecommunications device for the deaf (TDD) and teletypewriter (TTY) transmission and reception capability for the deaf and hearing-impaired, as the Contractor's toll-free number, unless otherwise agreed to by EOHHS.

Provide access through the toll-free number to Member and Provider Customer Service representatives via dedicated menu option(s).

Maintain a telephone system that performs the following functions:

Assigns priority status to Covered Individuals in crisis to ensure immediate response from a clinician staffing the Clinical Referral and Service Authorization line;

Provides a sufficient number of telephone lines and trunks to handle all incoming calls so that no caller receives a busy signal;

Provides a means for callers to leave messages for the Contractor after business hours, and ensures that such calls are handled by the next business day; and

Allows the Contractor to directly connect the caller to other agencies or contractors, as specified by EOHHS.

Submit to EOHHS for approval 30 days prior to the Service Start Date:

A description of its working automated telephone system with menu options that include:

the Clinical Referral and Service Authorization line;

Member Services, Provider Relations, and PCC Hotline; and

a diagram for direct call distribution to the Contractor's telephone queues;

The proposed script for the telephone system's greeting; and

A description of the messages and prompts that ate part of the automated telephone system.

Develop, implement, maintain and enhance, as necessary, a call management system for Clinical Authorization and Referral and Member and Provider Customer Service calls that:

Records and tracks all calls handled, to include the following information:

name of caller and Covered Individual, Provider or PCC identification number, where applicable;

call date and time;

reason for the call;

disposition of the call, including whether the matter was resolved at the time of first contact if a complaint, was resolved by the end of the next business day, or if the call is pending resolution; and

if the call is pending resolution, additional information to assist in the escalation and resolution of outstanding issues.

Tracks Covered Individual call volume by PCC, DYS, DCF, TPL, etc.; and

Provides service representatives with online access to relevant information from previous calls.

Arrange for appropriate telephone book listings of the Contractor, as approved by EOHHS, to be submitted for publication at least one month prior to the Service Start Date.

Periodically, and as directed by EOHHS, evaluate the effectiveness of the Provider and Member Customer Services telephone system, and submit proposals for improvement to EOHHS.

Telephone Response Requirements

The Contractor shall ensure that:

Calls from Covered Individuals in crisis are handled immediately by a staff clinician;

For each line, including Clinical Referral and Service Authorizations, Member and Provider Customer Service and PCC Hotlines, staff make best efforts to answer all calls from Covered Individuals and Providers and PCCs within 30 seconds of when callers selects the menu option for the line they are trying to reach; but in no case shall fewer than 90 percent of these calls be answered within 30 seconds;

Calls to all lines have an abandoned call rate of less than 5 percent; and

Calls to each specific line are answered within the specified time frames by the appropriate staff:

Calls to clinical lines are answered by a clinician;

Calls to Customer Service are answered by customer service staff; and

Calls to the PCC Hotline are answered by trained and dedicated Provider service representatives.

Other Contractor-Managed Data Systems for Specific Requirements of the Contract

The Contractor shall maintain data systems, which may be standalone, web-based, or integrated into its larger Information System, that are required to manage and report on specific program requirements of the Contract. These data systems include but are not limited to:

ESP Encounter database as described in **Section 3.4.C.6.c**.

Behavioral Health Service Access System database for use by providers to locate available capacity for inpatient, and certain Diversionary and CBHI services, as described in **Section 3.4.A.12**.

CSA referral and enrollment data tracking system as described in **Section 3.5.E.8**.

PCC Plan action plan database as described in **Section 5.2.C.3**.

Clinical database for Care Management as described in **Section 6.2.B.6**.

Reporting

The Contractor shall submit to EOHHS all required reports related to MIS, telephone or other technical systems, as described in this **Section 9** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

PAYMENT AND FINANCIAL PROVISIONS

General Financial Provisions

Payment for Provision of Covered Services to Covered Individuals

EOHHS shall make payments to the Contractor in accordance with the payment provisions in this **Section 10.1**. Payments to the Contractor for Covered Individuals, including the Behavioral Health Covered Services Capitation Rates, the Administrative Component of the BH Covered Services Capitation Rates, payments made for Risk Sharing, and payments made for Performance Incentive Arrangements including Pay for Performance and Care Management Incentive Payments shall be made in accordance with 42 CFR 438.6. Except as expressly set forth herein, the Contractor shall accept the payments set forth below as payment in full for the provision of Behavioral Health Covered Services and all other activities described in this Contract.

All payments under this Contract are subject to state appropriation and all necessary federal approvals.

Behavioral Health Covered Services Capitation Rates

EOHHS shall pay the Contractor Behavioral Health Covered Services Capitation Rates for all BH Covered Services provided under this Contract except as set forth in **Section 10.1.A.2** below. All Behavioral Health Covered Services Capitation Rates shall be as set forth in **Appendix H-1**.

Exclusions from the Behavioral Health Covered Services Capitation Rates

EOHHS shall pay the Contractor for services provided by ESPs to Uninsured Individuals and persons with Medicare only according to the methodology set forth in **Section 10.10**.

Risk-Sharing Arrangements

The Contractor and EOHHS may share financial risk for Behavioral Health Covered Services. Risk sharing arrangements shall be as set forth in **Appendix H-1**.

Administrative Component of the Behavioral Health Covered Services Capitation Rate and up to 20% of Care Management Program.

EOHHS shall pay the Contractor an Administrative Component of the Behavioral Health Covered Services and up to 20% of Care Management Program Capitation Rate for each Contract Year as set forth in **Appendix H-1**.

The Administrative Component of the Behavioral Health Covered Services Capitation Rate shall be based on a Per Member (Covered Individual) Per Day (PMPD) rate that is determined using the Covered Individuals served under the Contractor's BHP.

Payment shall be for services as set forth in **Appendices G** and **H-1**.

Performance Incentive Arrangements

EOHHS and the Contractor may establish Performance Incentive Arrangements. If such Performance Incentive Arrangements are established, EOHHS shall pay the Contractor Performance Incentive Arrangement payments based on EOHHS's assessment of the Contractor's achievement of such Performance Incentives and all terms and conditions for payment as set forth in this Contract and **Appendices G** and **H-1**. Any such incentive payment shall not result in payments in excess of 105 percent of the approved Capitation Payments.

PCC Plan Management Support Services

EOHHS shall pay the Contractor for the PCC Plan Management Support Services activities described in **Section 5** and other sections of the Contract as identified by the parties each Contract Year, as set forth in **Appendix H-1**.
The PCC Plan Management Support payments shall be based on a Per Member (Enrollee) Per Day (PMPD) rate that is determined using the Enrollees in the PCC Plan.

Payment for Provision for DMH Specialty Programs Services

EOHHS shall pay the Contractor to provide DMH Specialty Programs services. Such payments shall include a DMH Specialty Programs Administrative Compensation Rate and a DMH Specialty Programs Service Compensation Rate as set forth in **Appendix H-1**.

Contractor's Use of Earnings for Compliance with Financial Stability Requirements

In no event shall any portion of the any payments made under this Contract, other than earnings, be used to pay the Contractor's cost for compliance with financial stability provisions (**Section 10.12.C**).

Modification of Covered Services

If, at any time during the term of the Contract, EOHHS directs the Contractor to eliminate or modify a BH Covered Services or DMH Specialty Program, the Contractor shall accept a modification in Behavioral Health Covered Services Capitation Rates or in the DMH Specialty Programs Payments, which shall be calculated by EOHHS in consultation with the Contractor.

Periodic Rate Review

In its discretion, at any time, EOHHS may review with the Contractor BH Covered Services Capitation Rates and the other financial provisions of this Contract to determine if such provisions should be adjusted due to changes in enrollment, case mix, or other factors. To the extent required by applicable federal law, such payment adjustments shall comply with the principles of actuarial soundness as determined by EOHHS in accordance with 42 CFR 438.6. In the event that EOHHS performs such a Periodic Rate Review and proposes modifications to any financial provisions as a result, the Contractor shall have 60 days to accept such modifications. In the event that the Contractor does not accept the financial

provisions within 60 days, EOHHS may terminate the Contract and the provisions of **Section 13.16.B** shall apply.

Annual Negotiation of Financial Terms

In determining the financial terms of the Contract, the Contractor shall meet with EOHHS annually to renegotiate the financial terms for each Contract Year. Such meetings shall begin no later than three months before the end of each Contract Year. EOHHS shall incorporate annual financial terms into the Contract into the Contract as **Appendix H-1**.

Failure to Accept Financial Provisions

In the event that the Contractor does not accept financial provisions for the next Contract Year by the first day of the new Contract Year, EOHHS shall continue to pay the Contractor under the current year's financial provisions and the Contractor shall accept such payment as payment in full under the Contract subject to subsections **a** and **b** below. EOHHS may halt all new Enrollee assignments into the PCC Plan until the Contractor accepts the financial provisions offered by EOHHS.

In the event that any component of the prior year's financial provisions are higher than the financial provisions for the new Contract Year that the Contractor ultimately accepts, EOHHS may recoup the higher payments made during the interim period.

In the event that any component of the prior year's financial provisions are lower than the financial provisions for the new Contract Year that the Contractor ultimately accepts, EOHHS will not retroactively adjust the lower payments made during the interim period.

In the event that the Contractor does not accept the financial provisions within 60 days of EOHHS's offer, EOHHS may terminate the Contract in accordance with **Section 13.16.B**.

If the Contractor does not accept the financial terms within 60 days of EOHHS's offer, EOHHS may terminate the Contract and the Contractor shall be obligated to continue to perform all obligations under the Contract as described in **Section 13.16.E**, until such time as all Covered Individuals are disenrolled from the Contractor's BHP. The Contractor shall accept the lower of the prior year's financial provisions or the EOHHS financial provision offer as payment in full during this time period.

Responsibilities of Chief Financial Officer

The Contractor shall employ a Chief Financial Officer who shall be responsible for overseeing all financial provisions and requirements of this Contract, including but not limited to the following:

Serving as the Contractor's liaison to EOHHS's financial representatives on all financial matters, including payments, reconciliations, and financial forecasting.

Validating the accuracy and completeness of all financial reports required under this Contract.

Payment for Provision of Services by Indian Health Care Providers to Indian Enrollees

All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

1. The Contractor shall offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services;
2. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to MCO Covered Services for Indian Enrollees;
3. The Contractor shall pay both network and non-network Indian Health Care Providers who provide MCO Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the MCO Covered Service provided by a non-Indian Health Care Provider;
4. The Contractor shall make prompt payment to Indian Health Care Providers; and
5. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider.

Rating Categories (RC) for Covered Individuals

RC I (Families) excluding Children under 21 with TPL

RC I includes MassHealth Members under age 65 who are enrolled in MassHealth Standard, including individuals receiving Transitional Aid to Families with Dependent Children (TAFDC) benefits; MassHealth Members who are categorically related to the TAFDC program, (excluding spend-down cases); MassHealth Members under age 65 under the Refugee Resettlement Program, MassHealth Members in MassHealth (Family Assistance); RC I excludes individuals who have Third-Party Liability coverage.

RC I Children under 21 with TPL Only

RC I Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard under age 21 with Third- Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

RC II (Disabled) excluding Children under 21 with TPL

RC II includes: MassHealth Members under age 65 who are disabled and receiving Supplemental Security Income (SSI), excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members who are disabled, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members receiving SSI and Massachusetts Commission for the Blind benefits, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members of the Massachusetts Commission for the Blind excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Standard (Disabled) Members; and Members of MassHealth CommonHealth who have no Third-Party Liability coverage.

RC II Children under 21 with TPL Only

RC II Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard (Disabled) and CommonHealth under age 21 with Third-Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

RC V (Basic)

RC V includes MassHealth Members over the age of 18 and under the age of 65 who qualify under EOHHS's MassHealth Basic eligibility criteria, which includes persons who have been identified by DMH as getting services or as being on a waiting list to get services from the DMH, are "long-term unemployed," and have income at or below 100 percent of the federal poverty level

RC VII (Essential)

RC VII includes MassHealth Members over the age of 18 and under the age of 65, who qualify under MassHealth Essential eligibility criteria which includes (1) persons not currently working; (2) persons that have not worked in more than one year or, if a person has worked, that person has not earned enough to collect unemployment; (3) persons not eligible to collect unemployment benefits; (4) persons who have an immigration status that prevents them from getting MassHealth Standard, are long-term unemployed and meet MassHealth disability rules; and (5) persons who are not eligible for MassHealth Basic.

RC VIII (MFP)

RC VIII includes MassHealth Members enrolled in one of the two HCBS waivers called the MFP Community Living (MFP-CL) (HCBSG Benefit Plan) Waiver and MFP Residential Supports (MFP-RS) (HCBSH Benefit Plan) Waiver.

RC IX (CarePlus)

RC IX includes Covered Individuals over the age of 20 and under the age of 65 with incomes up to 133 percent of the Federal Poverty Level (FPL), who are not pregnant, disabled, or a parent or a caretaker relative of a child under age 19, or eligible for other MassHealth coverage. Also excluded from RC IX are individuals who are dually-eligible for Medicaid and Medicare.

RC X (CarePlus)

RC X includes Covered Individuals over the age 20 and under the age of 65 with incomes up to 133 percent of the FPL, who are receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance. Excluded from RC X are individuals who are pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage. Also excluded from RC X are individuals who are dually-eligible for Medicaid and Medicare.

Payment Methodology for BH Covered Services Capitation Rates

Monthly Estimated BH Covered Services Capitation Rate Payment Process

Each month EOHHS shall pay the Contractor an Estimated Capitation Payment, which will include the BH Covered Services Capitation Payment, in accordance with the following methodology. EOHHS shall:

Convert the BH Covered Services Capitation Rates into a Per-Covered Individual Per-Day (PMPD) amount for each RC by multiplying the Per-Member Per-Month (PMPM) payment rate by 12, then dividing by 365; for Contract Year One, such calculation shall be made by multiplying the PMPM payment rate by 9 then dividing by 273.

Multiply the estimated number of Eligible Days for the month, as determined by EOHHS in each RC, by the PMPD amount for the RC.

Sum the calculations described in subsection **2** for each RC; this is the Estimated Monthly BH Covered Services Capitation Amount.

Estimated Monthly BH Covered Services Capitation Amount Reconciliation Process

EOHHS shall perform a monthly reconciliation of the Estimated Monthly BH Covered Services Capitation Payment Amount calculated according to **Sections 10.3.A.1-2** against the actual number of Eligible Days by RC, as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

Multiply the actual number of Eligible Days, as determined by EOHHS for each RC for the previous month, by the PMPD amount for each RC.

Sum the calculations for each RC described in subsection **a**; this is the Actual Monthly BH Covered Services Capitation Amount.

Compare the sum of the Estimated Monthly BH Covered Services Capitation Payment paid for the month against the Actual Monthly BH Covered Services Capitation Amount. This reconciliation shall occur monthly.

The Contractor shall provide any information necessary to complete such reconciliation in the time frame and format specified by EOHHS.

Based on the comparison described in subsection **1.c** above, EOHHS shall determine each month whether overpayments or underpayments were made to the Contractor.

EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Estimated Monthly BH Covered Services Capitation Payments or by another mechanism, as determined by EOHHS.

The Contractor shall remit to EOHHS the full amount of any overpayments made for the month. Such payments shall be made through an adjustment to a future Estimated Monthly BH Covered Services Capitation Payments or by another mechanism, as determined by EOHHS.

Monthly CarePlus Estimated Capitation Payment Process

EOHHS shall make capitation payments for Covered Individuals in Rating Categories IX and X, as follows:

Monthly, EOHHS shall pay the Contractor an Estimated Capitation Payment equal to the sum of the products of:

a. The number of Covered Individuals in Rating Categories IX and X in the Contractor's Plan as determined by EOHHS on the first day of the Payment Month, multiplied by

b. The Behavioral Health Covered Services Capitation Rates for each applicable Rating Category.

EOHHS shall include Covered Individuals in Rating Categories IX and X in the capitation calculation described in subsection 10.3.C.1. above as follows:

a. For Covered Individuals in Rating Categories IX and X who have an Effective Date of Enrollment with the Contractor's Plan as of the first day of the Payment Month, EOHHS shall include such Covered Individuals in Rating Categories IX and X in the capitation calculation for that Payment Month.

b. For Covered Individuals in Rating Categories IX and X who have an Effective Date of Enrollment with the Contractor's Plan after the first day of the Payment Month, EOHHS shall include such Covered Individuals in Rating Categories IX and X in the capitation calculation starting with the following Payment Month.

For Covered Individuals in Rating Categories IX and X for whom EOHHS has assigned a specific disenrollment date due to a qualifying event such as a member attaining age 65 within the Payment Month, EOHHS shall make a pro-rated Estimated Capitation Payment to the Contractor. The pro-rated Estimated Capitation Payment will equal:

a. The Behavioral Health Covered Services Capitation Rate,

b. Multiplied by the number of Enrollee Days during the Payment Month

c. Divided by the total number of days in the Payment Month.

Payment Methodology for the Administrative Component of the BH Covered Services Capitation Rates

Estimated Monthly Administrative Payments

Each month EOHHS shall pay the Contractor an Estimated Administrative Payment, which will include the care management administrative rate, in accordance with the following methodology:

EOHHS shall convert the PMPM Rates into a Per-Member (Covered Individual) Per-Day (PMPD) amount by multiplying the Per-Member Per-Month (PMPM) payment rate by 12, then dividing by 365; for Contract Year One, such calculation shall be made by multiplying the PMPM payment rate by 9, then dividing by 273; and

Multiply the estimated number of Eligible Days for the month, as determined by EOHHS, by the PMPD; this is the Estimated Monthly Administrative Component of the BH Covered Services Capitation Rate amount.

Estimated Monthly Administrative Reconciliation Process

EOHHS shall perform a monthly reconciliation of the Estimated Monthly Payment for Administrative Component of the BH Covered Services Capitation Rate calculated according to **Sections 10.4.B.1-2** against the actual number of Eligible Days by Covered Individual and Enrollees in the Care Management portion of the administrative payment as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

Multiply the actual number of Eligible Days, as determined by EOHHS for Covered Individual and Enrollees for the previous month, by the PMPD BH Administrative rate and the Care Management administrative rate amount; this is the Actual Monthly Administrative Component of the BH Covered Services Capitation Rate.

Compare the Estimated Monthly Administrative Component of the BH Covered Services paid for the month against the Actual Monthly Administrative Component of the BH Covered Services Capitation Rate.

The Contractor shall provide any information necessary to complete such reconciliation in the time frame and format specified by EOHHS.

Based on the comparison described in subsection **1.b** above, EOHHS shall determine each month whether overpayments or underpayments were made to the Contractor.

EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Estimated Monthly Administrative Component of the BH Covered Services Capitation Rates payment or by another mechanism, as determined by EOHHS.

The Contractor shall remit to EOHHS the full amount of any overpayments made for the month. Such payments shall be made through an adjustment to future Estimated Monthly Administrative Component of the BH Covered Services Capitation Rates payment or by another mechanism, as determined by EOHHS.

Payment Methodology for PCC Plan Management Support Services

Estimated PCC Plan Management Support Services Payment

Each month EOHHS shall pay the Contractor an Estimated PCC Plan Management Support Services Payment, in accordance with the following methodology. EOHHS shall:

Convert the PMPM Rates into a per-Enrollee per-day (PMPD) amount by multiplying the Per-Member Per-Month (PMPM) payment rate by 12, then dividing by 365; for Contract Year One, such calculation shall be made by multiplying the PMPM payment rate by 9, then dividing by 273.

Multiply the estimated number of Eligible Days for the month, as determined by EOHHS, by the PMPD; this is the Estimated Monthly PCC Plan Management Support Services Payment Amount.

Estimated PCC Plan Management Support Services Payment Reconciliation Process

EOHHS shall perform a monthly reconciliation of the Estimated Monthly Payment for the PCC Plan Management Support Services calculated according to **Sections 10.5.B.1-2** against the actual number of Eligible Days by Enrollee, as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

Multiply the actual number of Eligible Days, as determined by EOHHS for Enrollees for the previous month, by the PMPD amount; this is the Actual Monthly PCC Plan Management Support Services Payment.

Compare the Estimated PCC Plan Management Support Services Payment paid for the month against the Actual Monthly PCC Plan Management Support Services Amount.

The Contractor shall provide any information necessary to complete such reconciliation in the time frame and format specified by EOHHS.

Based on the comparison described in subsection **1.b** above, EOHHS shall determine each month whether overpayments or underpayments were made to the Contractor.

EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Estimated PCC Plan Management Support Services Payments or by another mechanism, as determined by EOHHS.

The Contractor shall remit to EOHHS the full amount of any overpayments made for the month. Such payments shall be made through an adjustment to future Estimated PCC Plan Management Support Services Payments or by another mechanism, as determined by EOHHS.

Risk-Sharing Arrangements

General Provisions

There may be distinct financial risk-sharing arrangements for the Behavioral Health Covered Services Component of the Capitation Rates paid for under the Rates for RC I excluding Children under 21 with TPL; RC I Children under 21 with TPL only; RC II excluding Children under 21 with TPL; RC II Children under 21 with TPL only; and RC IX and RC X, as applicable, as set forth in **Appendix H-1**.

The arrangement described in this **Section 10.6** may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.

All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor's expenditures related to Covered Individuals, as determined by EOHHS.

The Contractor's Behavioral Health Covered Services Capitation Rate revenue shall mean the sum of the applicable 12 Actual Monthly Behavioral Health Covered Services Capitation Rate payments for the Contract Year, as determined in accordance with **Section 10.3.B.1.b**. This calculation shall be used to determine the Contractor's revenue for the Behavioral Health Covered Services Capitation Rate.

By 210 days after the end of each Contract Year, the Contractor shall provide EOHHS with a report of actual expenditures for all of the services included in the Behavioral Health Covered Services Capitation Rate, subtracting any TPL recoveries retained by the Contractor pursuant to **Section 2.3.C.2**. The report of expenditures shall be based on all Claims paid through no fewer than 180 days, including the Contractor's best estimate of Claims incurred but not reported (IBNR) and any applicable

IBNR completion factor reported to EOHHS with the IBNR methodology report (see **Appendix E-1**). In the event that the above final report of actual expenditures includes an IBNR completion factor greater than 1 percent for total BH Covered Services, EOHHS reserves the right to conduct an audit of the Contractor's IBNR methodology.

EOHHS shall in its sole discretion make the final determination of IBNR, using the Contractor's report of actual expenditures to inform that determination.

EOHHS shall compare the actual PMPD Behavioral Health Covered Services Capitation Rate payments for the Contract Year to the Contractor's actual expenditures. Based on such comparison, and calculating any difference, EOHHS shall determine in accordance with **Section 10.3.B.2** whether overpayments or underpayments were made to the Contractor.

EOHHS shall pay the Contractor a final payment for the preceding Contract Year in accordance with the same methodology as described in **Section 10.3.B.2.a**.

The Contractor shall pay EOHHS a final payment for the preceding Contract Year in accordance with the same methodology as described in **Section 10.3.B.2.b**.

Notwithstanding the generality of the foregoing, if EOHHS determines that risk sharing arrangements result in payments that exceed the approved capitation rates and the excess payments exceed that total amount MassHealth would have paid on a fee for service basis for the BH Covered Services actually furnished to Covered Individuals, EOHHS shall re-price any or all of the Contractor's paid Claims so that the total final payments to the Contractor based on risk sharing arrangements do not exceed the amount MassHealth would have paid for the actual services provided to Covered Individuals on a Fee-For-Service basis.

Performance Incentive Arrangements

Overview

The Contractor may be eligible for three types of Performance Incentive Arrangements under this Contract: Pay for Performance (P4P), Care Management Performance Incentives and an ABA Incentive. Total Payments for Performance Incentive Arrangements may not exceed 105 percent of approved Capitation Payments.

Pay for Performance

The number of P4P measures in Contract Year One shall not exceed four measures. Each Contract Year thereafter during Contract negotiations, the Contractor shall propose to EOHHS a minimum of five P4P measures as described in **Section 8.6**, including the measure methodology and proposed improvement targets which the Contractor must meet in order to receive any P4P payments.

Each Contract Year, EOHHS may in its sole discretion approve, modify or disapprove any or all proposed P4P measures or supporting methodologies.

EOHHS shall make payments to the Contractor based on its performance on selected P4P measures, if agreed to by EOHHS. Partial payments may be made based on demonstration of incremental improvement.

Except as otherwise expressly stated, for any P4P and supporting methodology for which performance is determined by reference to a baseline, EOHHS shall in its sole discretion establish such baseline.

EOHHS shall have the sole authority for determining whether the Contractor has met, exceeded or fallen below any P4P measure. EOHHS shall make its determination as to whether the Contractor has achieved any P4P measure or incremental target, except if EOHHS has not received sufficient material information from the Contractor to make such a determination.

With the exception of the P4P measure on outpatient access and quality, the Contractor shall receive annual payment for performance, where earned, based on actual performance improvement no earlier than six months following the end of the calendar year of the measurement, as illustrated in the table below.

Baseline Measurement Year (Calendar Year)	Performance Measurement Year (Calendar Year	Payment
CY12	CY13	July 2014
CY13	CY14	July 2015

Care Management Performance Incentives

The Contractor may receive payment for Care Management based on a combination of its Administrative Component of the BH Covered Services Capitation Rates and earned Performance Incentives. The total Care Management Performance Incentives amount the Contractor may earn depends on how much of its Care Management Program (up to 20 percent of total costs) is paid through its Administrative Component of the BH Covered Services Capitation Rate, and the Contractor's success in engaging program Participants and improving health outcomes.

Engagement Performance Incentives

The Contractor may earn Per Participant Per Month payments based on Engagement of Participants in the Care Management Program.

The Contractor shall propose, subject to EOHHS approval, the minimum Engagement Targets by Tier and the PPPM rate per Tier.

The Contractor shall calculate and report on the number of Participants in Care Management on a monthly basis and shall be paid an Engagement PPPM, upon EOHHS review and approval, on a quarterly basis.

The Contractor shall be subject to reconciliation on an annual basis to ensure that the Contractor has met its Annual Projected Engagement Target of unduplicated Participants. Beginning in Contract Year Two, if the Contractor has not engaged the Annual Projected Engagement Targets by close of Contract Year Two, EOHHS will assess a penalty against the Contractor, using the following formula: EOHHS shall calculate the difference between the Annual Projected Engagement Target number of unduplicated Participants and the actual number of unduplicated Participants served in all Tiers. The penalty shall equal the difference multiplied by the weighted average of the Engagement PPPM for the Contract Year.

Engagement Performance Incentives will be calculated on a monthly basis and paid on a quarterly basis to the Contractor for all Participants who meet the Engagement definition for that month. The remainder of the Care Management outcomes Performance Incentives will be made on an annual and retrospective basis. Payments shall follow the schedule described in **Section 10.7.B**. Performance Incentive calculations shall be performed by EOHHS.

Care Management Outcome Performance Incentives

The Contractor may earn Care Management Outcome Performance Incentive payments based on its performance on designated outcomes measures as described in **Section 8.6.C** and **Appendix G**.

The number of measures in Contract Year One shall not exceed four measures. Each Contract Year thereafter during Contract negotiations, the Contractor shall propose to EOHHS a minimum of four outcome measures, including the measure methodology and proposed improvement targets which the Contractor must meet in order to receive any Care Management Outcome Performance Incentives.

EOHHS may in its sole discretion approve, modify or disapprove any proposed measure or supporting methodology.

The Contractor may receive partial payment for performance meeting set outcome measures targets, if agreed to by EOHHS.

Care Management Outcome Performance Incentive payments will be made on an annual and retrospective basis, no earlier than six months following the end of the calendar year.

Social Innovation Financing for Chronic Homelessness Program (SIF Program)

1. In the event the SIF Program described in **Section 4.8** is implemented by the Commonwealth prior to October 1, 2014, the Contractor shall receive a performance incentive for its participation in the SIF Program (the SIF Performance Incentive) if the Contractor attests, in the form and format specified by EOHHS, that the Contractor supported the SIF Program in accordance with **Section 4.8** as directed by EOHHS.

2. The SIF Performance Incentive shall be in an amount equal to the sum of the case rate payments the Contractor made to SIF Program providers as set forth in **Section 4.8.A**.
3. The SIF Performance Incentive shall be in effect July 1, 2014 through July 31, 2015.
4. The Contractor shall submit to EOHHS an attestation in accordance with Section 10.7.D.1 above, and reflecting all payments described in Section 10.7.D.2 above, that the Contractor made to its SIF Program providers in accordance with Section 4.8. The Contractor shall submit such attestation to EOHHS by December 31, 2015.

ABA Incentive

By December 31, 2015, the Contractor shall hire sufficient staff to provide ABA related technical assistant, ABA related network management activities, and ABA related utilization management activities. In addition, the Contractor shall hire at least one individual with extensive knowledge of ABA such as a Board Certified Behavioral Analyst (BCBA).

BH Covered Services Continuing Services Reconciliation

EOHHS shall perform a year-end Continuing Services reconciliation as follows:

The Contractor shall process and pay its Providers' Claims for all Continuing Services provided in accordance with **Section 7.6.E** at the Contractor's contracted rate with its Providers.

EOHHS shall perform a reconciliation by September 30 following the end of the Contract Year to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by BOH and which were provided following the conclusion of the Internal Appeal ("approved Continuing Service claims"); provided that the Contractor submits to EOHHS by 210 days following the end of the Contract Year all data regarding such services, as required in **Appendix E-1**.

EOHHS shall pay the Contractor no later than 60 days following the reconciliation set forth in subsection B the total value of the approved Continuing Service claims referenced in subsection B that were provided in the applicable Contract Year; provided that the Contractor timely submitted all data required by EOHHS pursuant to **Appendix E-1**.

Approved Continuing Service claims shall include, at a minimum, the following information:

Covered Individuals information, by RID, including date of birth, sex, dates of enrollment, the dates on which the Continuing Services were provided, and current enrollment status;

Costs incurred, by RID, including dates of service; and

Such other information as may be required pursuant to any EOHHS request for information.

The reconciliation payment procedures may include an audit, to be performed by EOHHS or its authorized agent, to verify all claims for the Covered Individuals by the Contractor. The

findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed by EOHHS. If an audit is not conducted, EOHHS shall reimburse the Contractor as otherwise provided herein.

Payment Methodology for DMH Specialty Programs and MCPAP

DMH Specialty Programs Payments

EOHHS shall pay the Contractor for DMH Specialty Programs, which include two components: a Service Component and an Administrative Component. The DMH Specialty Program Administrative Compensation Rate and DMH Specialty Program Services Compensation Rate shall be used to provide ESP Services for Uninsured Individuals and persons with Medicare only, as described in **Section 3.4** and Forensic Services as described in **Section 4.6** and **Appendix A-6.**

In no event shall any payment, other than the DMH Specialty Program Administrative Compensation Rate or the DMH Specialty Program Services Compensation Rate payments, be utilized by the Contractor as payment for DMH Specialty Program services provided to any Uninsured Individual and persons with Medicare only, or for the cost of administering DMH Specialty Program services.

The DMH Specialty Programs Service Compensation Rate shall be paid each month in an amount equal to one-twelfth of the annual budget for the Contract Year, as set forth in **Appendix H-1**.

EOHHS shall establish a DMH Specialty Program Administrative Compensation Rate payment for the administration of the DMH Specialty Program that is equal to the sum of: Direct Costs; Indirect Costs; and earnings, and such sum shall not exceed an agreed-upon amount, as set forth in **Appendix H-1**.

Earnings shall be an agreed-upon amount, as set forth in **Appendix H-1**.

Each month EOHHS shall pay the Contractor an amount equal to one-twelfth of the DMH Specialty Program Administrative Compensation Rate amount for the Contract Year set forth in **Appendix H-1**.

Reconciliation Process for Forensic Evaluation Services

EOHHS shall perform an annual reconciliation of Forensic Evaluation Services.

EOHHS shall determine annually whether overpayments or underpayments were made to the Contractor.

EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Forensic Evaluation Services or by another mechanism, as determined by EOHHS.

The Contractor shall remit to EOHHS the full amount of any overpayments. Such payments shall be made through an adjustment to a future Forensic Evaluation Services or by another mechanism, as determined by EOHHS.

Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for Forensic Evaluation Services funded by the DMH Specialty Program Service Component Rate described in this section until it has received funding from DMH in the amounts necessary to make any such payments.

Particular Payment Provisions for ESP Services for Uninsured Individuals and Persons with Medicare Only

General Provisions

The Contractor shall:

For ESP services for Uninsured Individuals and persons with Medicare only, require ESP Providers to bill other insurances (TPL), where available, and the Health Safety Net in accordance with applicable law (see also **Section 2.3.D**).

Pay ESPs the rate for ESP Services established by the Massachusetts Division of Healthcare Finance and Policy and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to ESPs for ESP Services for Uninsured Individuals and persons with Medicare only delivered under the Contract.

Not utilize the ESP Amount except to pay for ESP Services delivered to Uninsured Individuals and persons with Medicare only.

Payment Methodology

By May 1 of each year, EOHHS shall provide the Contractor with an estimated amount it expects to pay each ESP for ESP Services delivered on a Fee-for-Service basis by EOHHS.

Each year by May 31 the Contractor shall provide EOHHS with a report (see **Appendix E-1**) of the Contractor's estimate of the total amount it expects to pay for ESP Services, including both BH Covered Services and DMH Specialty Program delivered under the Contract.

Based on the Contractor's estimate of the amount it expects to pay for such ESP Services, EOHHS shall establish an ESP Amount for Uninsured Individuals and persons with Medicare only.

The ESP Amount shall be in accordance with **Appendix H-1**. The Contractor shall develop a plan to monitor and report on, throughout each Contract year, ESP expenditures for Uninsured Individuals and persons with Medicare only compared to the amount in **Appendix H-1**. Such report

shall also include monitoring of ESP expenditures for Covered Individuals.

Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for ESP Services funded by the DMH Specialty Program Service Component Rate described in this section until it has received funding from DMH in the amounts necessary to make any such payments.

Reconciliation Process for ESP Services Provided to Uninsured Individuals and Persons with Medicare Only

By 210 days after the end of each Contract Year, the Contractor shall provide EOHHS with a report (see **Appendix E-1**) of the Contractor's actual expenditures for ESP Services provided to Uninsured Individuals and persons with Medicare only, based on Claims paid through no later than 180 days, including its best estimate of IBNR Claims and any applicable IBNR completion factor reported to EOHHS.

EOHHS shall conduct a year-end reconciliation of the Contractor's estimated expenditures on ESP Services provided to Uninsured Individuals and persons with Medicare only delivered under the Contract against actual expenditures, including IBNR.

If actual expenditures are less than the Contractor's estimates, EOHHS shall recoup the difference from the Contractor.

If actual expenditures are greater than the Contractor's estimate, EOHHS shall pay the difference to the Contractor.

Payment Methodology for Comprehensive Primary Care Payment Covered Services

BH Rate

Each month the Contractor shall pay Tier 2 and 3 PCPR Providers the BH Rate associated with each Participating Site, for PCC Panel Enrollees, for the provision of Tier 2 or Tier 3 CPCP Covered Services identified in **Appendix J-5**.

The Contractor shall not pay the PCPR Provider for the Tier 1 portion of CPCP Rate, nor for any portion of the Medical Home Load. EOHHS pays Tier 1 CPCP Covered Services and Medical Home Load directly to the PCPR Provider.

EOHHS shall calculate the BH Rate according to the following formula:

The BH Rate = CPCP Rate – EOHHS share of CPCP, where the EOHHS share of CPCP is equal to Tier 1 Services Rate + Tier 2 or 3 Medical Home Load (MHL)

1. Tier 1 Services Rate = Tier 1 Billable Services Rate x Tier 1 PCAL x Tier 1 EESPA

2. Tier 2 or 3 MHL = 12.50 x Tier 2 or 3 PCAL x Tier 2 or 3 EESPA

Quarterly Receipt of CPCP Rate

Beginning with the second quarter of calendar year 2014, EOHHS shall provide the Contractor with the BH Rate for each Tier 2 or Tier 3 PCPR Provider's Participating Site on a quarterly basis, on or about the first Friday of the month prior to the start of each quarter year (e.g., June, September, December, March).

Monthly Receipt of the List of Attributed PCC Plan Enrollees

No later than the third Monday of each month, EOHHS shall make available to the Contractor a list of PCC Panel Enrollees assigned to Tier 2 and Tier 3 Participating Sites, as determined by EOHHS, for which EOHHS shall pay the PCPR Participant EOHHS' portion of the CPCP Rate.

Comparison of Enrollment Data

Each month, the Contractor shall produce a list of all PCC Plan Enrollees attributed to each Participating Site as of the first of that month, based on the Contractor's enrollment records, and shall send these reports to EOHHS as early as reasonably possible but not later than the 20th of every month.

The above-referenced list will include the following information for each identified PCC Plan Enrollee: name, MassHealth ID, attributed Participating Site, enrollment start date, and enrollment end date.

Timing of Payment to Tier 2 and Tier 3 PCPR Providers

The Contractor shall pay Participant within seven business days of Contractor's receipt from EOHHS of (a) the portion of the CPCP Rate that is based on Behavioral Health Services provided to Panel Enrollees (the "BH Rate") and (b) the monthly report of total Panel Enrollees, unless a different payment day is mutually agreed upon by EOHHS and the Contractor at least 30 days prior to the following month's scheduled payment to PCPR Providers.

Claims Adjudication for Tier 2 and Tier 3 PCPR Providers

The Contractor shall ensure that Tier 2 or Tier 3 PCPR Providers continue to submit claims to the Contractor for all CPCP Covered Services to ensure the accurate collection of Encounter data.

1. The Contractor shall provide no payment to Tier 2 or Tier 3 PCPR Providers for claims submitted that meet the following criteria (such claims shall be considered "zero-paid") with the exception of any Hold Harmless payment owed to PCPR Providers as describe in subsection **G**:

    a. The claim is for care provided to a PCC Panel Enrollee who is attributed to a PCPR Participating Site on the date of service based on Contractor's enrollment data;

b. The claim is for a Tier 2 or Tier 3 CPCP Covered Service in **Appendix J-2**; and

c. The billing entity is either the PCPR Provider to which the PCC Panel Enrollee is attributed on the date of service; or a Voluntary Pooled Provider that is also a Tier 2 or Tier 3 PCPR Provider.

2. The Contractor shall include PCPR Encounter data reflecting zero-paid claims in the monthly Encounter data feed sent to EOHHS, as required by Section **9.5.B**. Such claims shall include the FFS value of the claim (i.e., the Contractor shall not set the dollar value to zero as a result of zero-paid claims as described above.)

PCPR Provider Hold Harmless Payments

1. EOHHS shall calculate a Hold Harmless Payment for each PCPR Provider, and, for each Tier 2 or 3 PCPR Provider, shall calculate a Contractor portion of such payment, which Contractor shall be responsible for paying to each such Provider.

2. EOHHS shall calculate each PCPR Provider's Hold Harmless Payment in accordance with Section 4.1 of the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract (**Appendix J-1**).

3. EOHHS shall calculate the Contractor portion of each Tier 2 or Tier 3 PCPR Provider's Hold Harmless Payment as a percentage of that PCPR Provider's Hold Harmless Payment. That percentage shall be equal to

   a. The difference between:

      1) The total FFS value of claims that were submitted to Contractor by the PCPR Provider with dates of service during the Hold Harmless period and were zero-paid by Contractor, and
      2) The total amount of BH Rate payments made by Contractor to the PCPR Provider during the Hold Harmless period;

   b. Divided by the following difference:

      1) The total FFS value of all claims that were submitted by the PCPR Provider to Contractor and to EOHHS with dates of service during the Hold Harmless period and were zero-paid by Contractor or by EOHHS, minus
      2) The total amount of CPCP payments made by Contractor and EOHHS to the PCPR Provider during the Hold Harmless period.

4. EOHHS shall notify the Contractor of the amount of the Contractor portion of each Tier 2 or 3 PCPR Provider's Hold Harmless Payment for each Hold Harmless period. The Contractor may review the amount calculated by EOHHS as the Contractor portion for

accuracy and compliance with the calculation methods stated herein. The Contractor shall pay the Contractor portion to each such Provider by the next monthly PCPR payment.

EOHHS and Contractor Reconciliation for PCPR

1. EOHHS shall pay the Contractor for PCPR payments to PCPR Providers that exceed the FFS amount of payments the Contractor provides to Tier 2 or Tier 3 PCPR Providers for CPCP Covered Services.

2. EOHHS shall calculate the following for each period a Hold Harmless Payment is made. The Contractor may review the amount calculated by EOHHS for accuracy and compliance with the calculation methods stated herein.

a. EOHHS's payment to the Contractor for Tier 2 or 3 CPCP Covered Services for PCC Panel Enrollees attributed to Tier 2 or Tier 3 PCPR Provider shall equal the product of:

   1) the portion of the Contractor's BH Covered Services Capitation Rate described in **Sections 10.3.A** and **Section 10.3.B** that corresponds to Tier 2 or 3 CPCP Covered Services in **Appendix J-2**; and
   2) The total number of PCC Plan Enrollees attributed to PCPR Providers as of the first of the month utilizing the EOHHS lists described in **Section 10.11.C.**

b. Contractor's payment to Tier 2 or Tier 3 PCPR Providers for Tier 2 or Tier 3 CPCP Covered Services shall equal the sum of:

   1) the BH Rate paid by Contractor; plus
   2) the Hold Harmless Payments made by the Contractor; plus
   3) all FFS reimbursement for Tier 2 or 3 CPCP Covered Services in **Appendix J-2** rendered by providers to PCC Panel Enrollees attributed to another PCPR Provider.

   If the product of the calculation set forth in subparagraph b. above exceeds the product of the calculation set forth in subparagraph a. above, EOHHS shall pay the Contractor 100% of the difference.

c. Such payment shall allow for a six months of claims run out as well as additional lag for MassHealth to receive and process the data and make the requisite calculations.

EOHHS Payment to Contractor for PCPR

1. Any payment paid by EOHHS in accordance with the EOHHS – Contractor Reconciliation described in subsection **H** will be included in the calculation described in **Section 10.6.A.4**.

2. Any payment owed to EOHHS in accordance with the EOHHS Contractor Reconciliation described in subsection **H** will be included in the calculation described in **Section 10.6.A.7.**

Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP)

EOHHS shall pay the Contractor for its payments to ESPs for the MCI/RAP in accordance with Appendix H-1, Section 4. No additional payment will be provided by EOHHS to the Contractor for the operation of MCI/RAP.

Health Insurer Provider Fee Adjustment

Each year, to account for the portion of the Contractor's Health Insurer Provider Fee under Section 9010 of the ACA (the HIPF) that is allocable to capitation payments made by EOHHS to the Contractor under this Contract (sometimes referred to as "MassHealth premiums", a type of premium under Section 9010):

A. Each year, Contractor shall provide EOHHS with information about the Contractor's HIPF, as requested by EOHHS, including but not limited to the bill the Contractor receives from the U.S. Internal Revenue Service.
B. EOHHS shall calculate and perform an adjustment set forth in **Appendix H-1, Exhibit 1** to the Contractor's Capitation Rates to account for the portion of the Contractor's HIPF that is allocable to capitation payments made by EOHHS to the Contractor under this Contract and, subject to federal financial participation for the tax liability related to the HIPF.
C. For Calendar Year 2013, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after October 1, 2014.

Financial Requirements

Direct Service Reserve Account

The Contractor shall establish a Direct Service Reserve Account (DSRA) into which all payments received from EOHHS must be deposited.

The DSRA shall be:

An interest-bearing trust account in a banking institution located in Massachusetts and approved by EOHHS. The Commonwealth of Massachusetts shall have the right and title to any and all interest earned in the DSRA.

Maintained, to the extent legally permissible, in a manner that prevents creditors of the Contractor from in any way encumbering or acquiring any funds in the DSRA.

In no event shall funds in the DSRA be used by the Contractor or any other agent or third party to satisfy, temporarily or otherwise, any Contractor liability, or for any other purpose except as provided under the Contract.

EOHHS may require at any time that the Contractor confer upon an authorized representative of EOHHS or a third party approved by EOHHS the obligation to approve all withdrawals and countersign all checks drawn on the DSRA.

The Contractor shall obtain approval of all aspects of the DSRA from EOHHS before establishing or making any changes to the account, and shall make changes to the DSRA at the direction of EOHHS, as necessary.

The Contractor shall transfer all deposits other than deposits for the BH Covered Services Capitation Rate and the DMH Specialty Programs Services Compensation Rate out of the DSRA within seven business days of receiving them.

The Contractor shall transmit all interest income from the DSRA, net of bank charges, to EOHHS in the form of a check payable to the Commonwealth of Massachusetts, twice a year on dates to be specified by EOHHS.

In no case shall the Contractor use interest income as any Earnings or bonus payment.

The Contractor shall exclude interest income from reconciliations of administrative and service expenditures.

EOHHS may, at any time and at its discretion, audit the Contractor’s administration and use of the DSRA funds consistent with the Contract requirements.

The Contractor shall comply with the following requirements relative to the management of the DSRA:

Separately tracking the following types of deposits from EOHHS into the DSRA:

BH Covered Services Capitation Rate payments, which includes the Administrative Component of the BH Covered Services Capitation Rate payments;

Care Management Engagement payment;

All Performance Incentive Arrangement payments;

PCC Plan Management Support Services payments;

DMH Specialty Services payments; and

DMH Administrative payments.

Establishing an audit trail that evidences that all payments and transfers from the DSRA are made from deposits received from EOHHS for that express purpose; specifically, that:

All payments from the DSRA for BH Covered Services are made from deposits received from EOHHS for Covered Services for Covered Individuals, and the administration and arrangement of BH Covered Services are made from deposits from EOHHS for that purpose (the Administrative Component of the BH Covered Services Capitation Rate);

All transfers from the DSRA for the Care Management Program-Engagement are made from deposits received from EOHHS for the Care Management Program;

All transfers from the DSRA for PCC Plan Management Support Services are made from deposits received from EOHHS for the PCC Plan Management Support Services; and

All payments from the DSRA for DMH Specialty Programs are made from deposits received from EOHHS for DMH Specialty Programs.

Tracking the interest earned on all deposits into the DSRA.

Except as specifically set forth in this **Section 10.12.A**, the Contractor shall not withdraw funds from the DSRA except to pay Claims properly submitted by Providers for Covered Services authorized by the Contractor pursuant to the Contract.

The Contractor and EOHHS shall reconcile deposits into and transfers from the DSRA within 120 days of the end of each state fiscal year for the preceding fiscal year.

Financial Solvency Requirements

Throughout the term of the Contract, the Contractor shall meet the solvency standards established by the Massachusetts Division of Insurance for private health maintenance organizations, or be licensed or certified by the Massachusetts Division of Insurance as a risk-bearing entity.

Financial Stability

Throughout the term of this Contract, the Contractor shall:

Remain financially stable.

Maintain adequate protection against insolvency in an amount determined by EOHHS to be adequate to both:

Provide to Covered Individuals all Covered Services required by this Contract for a period of 45 days following the date of insolvency; and

Continue to provide all such services to Covered Individuals who are receiving Inpatient Services at the date of insolvency until the date of their discharge.

The Contractor shall maintain liability protection sufficient to protect itself against any losses arising from any claims against it, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance (see also **Section 13.35**).

Performance Guarantees and Additional Security

Insolvency Reserve

The Insolvency Reserve shall be defined as the funding resources necessary to meet the costs of providing services to Covered Individuals for a period of 45 days in the event that the Contractor is determined insolvent. Please note that for CY1 the Contractor shall provide at minimum fifty-percent of the Insolvency Reserve, consistent with the risk corridor calculation.

EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the Contractor within 45 days of the start of the Contract Year.

The Insolvency Reserve calculation shall be an amount equal to 45 days of the Contractor's capitation payment revenue.

Within 30 calendar days of receipt of the Insolvency Reserve calculation, the Contractor shall submit to EOHHS written documentation of its ability to satisfy the Insolvency Reserve requirement. The documentation shall be signed and certified by the Contractor's chief financial officer.

Submit to EOHHS for approval, documentation that the Contractor has satisfied the Insolvency Reserve Requirement through:

Restricted cash reserves of $10,000,000 or 16.7%; and

any combination equaling 83.3% of the following:

Net worth of the Contractor (exclusive of any restricted cash reserves);

Performance bond or guarantee;

Insolvency insurance;

An irrevocable letter of credit; and

A written guarantee from the Contractor's parent organization.

Prior to the Service Start Date the Contractor shall provide EOHHS with:

Performance Guarantees as specified in **Appendix H-2**, the form of which shall be subject to EOHHS's prior review and approval.

A promissory note from the Contractor's parent(s) to guarantee performance of the Contractor's obligation to provide Covered Services in the event of the Contractor's insolvency, the form and amount of which shall be subject to EOHHS's prior review and approval.

A promissory note from the Contractor's parent(s) to guarantee performance of the Contractor's obligations to perform activities related to the administration of the Contract in the event of the Contractor's insolvency, the form and amount of which shall be subject to EOHHS's prior review and approval.

Other Financial Requirements

The Contractor shall:

Ensure that an independent financial audit of the Contractor is performed annually, which complies with the following requirements:

Provides EOHHS with the Contractor's most recent audited financial statements; and

Provides an independent auditor's report on the system processing of the transactions using the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards SAS 70 protocol and Chapter 647 of the Acts of 1989 (also known as the Internal Control Law).

Submit annually, by September 30th, a Financial Ratio Analysis that describes the Contractor's performance for financial ratios required by EOHHS in accordance with the definitions in **Appendix E**, **Exhibit 3A** and the format in **Appendix E**, **Exhibit 3B.** The report shall be generated from the Contractor's audited financial statements.

Submit on an annual basis after each annual audit a representation letter signed by the Contractor's Chief Financial Officer and its independent auditor

certifying that its organization is in sound financial condition and that all issues have been fully disclosed.

Maintain separate records of all Direct and Indirect administrative Costs, in accordance with generally accepted accounting principles, and make these financial records available to EOHHS on a quarterly basis, for audit purposes.

Obtain EOHHS's approval of and utilize a methodology to estimate IBNR claims adjustments.

Immediately notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the Chief Executive Officer or Chief Financial Officer to notify its Board of the potential for insolvency.

Notify EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract.

Advise EOHHS no later than 30 days prior to execution of any significant organizational changes, new contracts or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract.

Provider Preventable Conditions

In accordance with 42 CFR 438.6(f)(2), the Contractor shall:

As a condition of payment, comply with the requirements mandating Provider identification of Provider Preventable Conditions, as well as the prohibition against payment for Provider Preventable Conditions as set forth in 42 CFR 434.6(a)(12) and 447.26;

Report all identified Provider Preventable Conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements specified in accordance with **Section 2.3.F** or **Appendix E**.

Reporting

The Contractor shall submit to EOHHS all required financial reports, as described in this **Section 10** or in **Appendix E**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc financial reports required by EOHHS in accordance with **Section 11.2.B**.

Alternative Payment Methodology for CBHI Intensive Care Coordination Services

Under the direction and with the approval of EOHHS, the Contractor shall develop and implement an alternative payment methodology for CBHI Intensive Care Coordination services."

Section 10.17 MFP Claim Information Submission

The Contractor shall submit claim information to EOHHS or its agent for all in-network behavioral health services provided for all MFP Waiver Participants pre-transition. Such claim information shall not be submitted until after the date of discharge, i.e. once the member has transitioned to the community. EOHHS or its agent shall review the information submitted by the Contractor prior to submitting claims information to MMIS for processing and payment to the Contractor. The rate for in-network behavioral health services provided pre-transition shall be in accordance with the Contractor's regular fee schedule for the specific behavioral health service provided to the member.

REPORTING AND DATA SUBMISSIONS

Data Requirements for Data

General Requirements

The Contractor shall provide and require its subcontractors to:

provide any and all information EOHHS requires under the Contract related to the performance of the Contractor's responsibilities;

provide any and all information EOHHS requires in order to comply with the Balanced Budget Act of 1997 or any other federal or state laws and regulations; and

provide EOHHS and DMH with any and all data to meet all applicable federal and state reporting requirements within the legally required time frames.

Data Certification Requirements

In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive or Chief Financial Officer, or a person who has delegated authority to sign for and who reports directly to the Contractor's Chief Executive or Chief Financial Officer, shall, at the time of submission of the types of information, data, reports and other documentation listed below, sign and submit to EOHHS **Appendix E-2** certifying that the information, data, and documentation being submitted by the Contractor is true, accurate, and complete to the best of his or her knowledge, information and belief, after reasonable inquiry:

data on which payments to the Contractor are based;

all enrollment information, Encounter data, and measurement data; and

data and other information required by EOHHS, including but not limited to reports and data described in this Contract.

The Contractor shall submit the certification concurrently with the certified data.

Additional Clinical Data

Upon request of EOHHS, the Contractor shall participate in the development of specifications for a data set consisting of clinical data in the Contractor's Information Systems that include Covered Individual identifier, and data on participation in the Children's Behavioral Health Initiative, Care Management Program, and special populations, which the Contractor shall produce and submit to EOHHS in the frequency and format to be determined by EOHHS.

Corrective Action for Inadequate Data

If EOHHS determines that the Contractor's Encounter data are complete and accurate for less than 90 percent of the data elements contained in the CMS-approved minimum data set

(MDS), the Contractor shall implement a corrective action approved by EOHHS to bring the accuracy to the acceptable level. EOHHS may impose daily financial penalties until the Contractor's deficiencies are corrected.

Requirements for Reporting

General Requirements

The Contractor shall:

Be responsible for all administrative costs associated with the development, production, mailing and delivery of all reports required under the Contract.

Submit to EOHHS all required reports in accordance with the specifications, templates and time frames described in this Contract and its Appendices, specifically including but not limited to the reports described in **Appendix E-1**, unless otherwise directed or agreed to by EOHHS. Any modifications, revisions or enhancements the Contractor proposes to make to any reports must be submitted to EOHHS for its approval prior to making such changes. EOHHS may update or replace **Appendix E-1** without the need for a Contract amendment

Work with EOHHS to correct or modify any reports as directed by EOHHS and resubmit them to EOHHS for final acceptance and approval within agreed-upon time frames.

At the written request of EOHHS's Director of Behavioral Health Programs or designee, or at the written or oral request of the State Office of the Inspector General or Office of the Attorney General, provide additional ad hoc or periodic reports, including any reports EOHHS asks the Contractor to produce as a result of an investigation into the performance of a provider, or analyses of data related to the Contract, according to a schedule and format specified or agreed to by EOHHS. Ad hoc reports shall be requested for one-time or non-routine submission to EOHHS or other agency designated by EOHHS.

Have the capacity to display data graphically, in tables, and in charts, as directed by EOHHS.

Ensure that all reports are identified with a cover page that includes at least the following information:

title of the report;

due date of the report;

production date of the report;

contact person for questions regarding the report;

data sources for the report;

reporting interval;

date range covered by the report; and

methodology employed to develop the information for the report.

Provide with each report a narrative summary of the key findings contained in the report, unless otherwise agreed to by EOHHS, actions taken or planned next steps related to those findings.

Deliver all reports to EOHHS electronically. The Contractor and EOHHS shall work with the MassHealth end users and IT to develop the best method for electronic report delivery in a format and media compatible with EOHHS' software and hardware requirements. The electronic submission must be organized with clearly labeled electronic files with the documented named with the report name and date, as well as an electronic table of contents.

Provide EOHHS and DMH with reports to meet all applicable federal and state reporting requirements within the legally required time frames.

Reporting Timetables

The Contractor shall provide reports to EOHHS according to the following timetable, unless otherwise specified or approved by EOHHS. All references to "annual" or "year-to-date" reports or data refer to the Contract Year, unless otherwise specified.

Reportable Adverse Incidents – Use secure e-mail system to send Reportable Adverse Incident reports to EOHHS by 5:00 p.m. (Eastern Time) on the same day that the Contractor receives Reportable Adverse Incident notification by 3:00 p.m. on a business day, in accordance with the established protocol. Submit Reportable Adverse Incident reports to EOHHS by the next business day if the Contractor receives Reportable Adverse Incident notification after 3:00 p.m. or on a non-business day, in accordance with the established protocol, unless otherwise approved by EOHHS.

Weekly Reports – no later than 5:00 p.m. the next business day following the week reported.

Monthly Reports – no later than 5:00 p.m. on the 20th day of the month immediately following the month reported for non-Claims-based reports; Claims-based reports will allow for a 90-day Claims lag. If the 20th of the month falls on a non-business day, the reports will be due on the next business day. Monthly reports due October 20, January 20, April 20, and July 20 may be submitted with quarterly reports.

Quarterly Reports – no later than 5:00 p.m. on the 30th day of the month following the end of the quarter reported, for non-Claims-based reports, i.e., October 30, January 30, April 30, and July 30; or, if the 30th of the

month falls on a non-business day, the next business day. Quarterly reports due January 30 and July 30 may be submitted with semiannual reports. Claims-based reports shall allow for a 90-day Claims lag and report time, so that, for example, reports due on October 30th will present data for service dates for the quarter from April-June.

Semiannual Reports – no later than 5:00 p.m. on the 30th day following the end of the semiannual period reported, for non-Claims-based reports, i.e., January 30 and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Semiannual reports due July 30 may be submitted with annual reports. Claims-based reports shall allow for a 90-day Claims lag, so that, for example, the report due on January 30th will present data through September 30th.

Annual Reports – no later than 5:00 p.m. on August 15 or, if August 15 falls on a non-business day, the next business day. Claims-based annual reports will allow for a 90-day Claims lag, so data due on August 15th will be for Claims no later than April.

One-time, Periodic, and Ad Hoc Reports – no later than the time stated, or as directed by EOHHS.

Corrective Action for Late or Incomplete Reports

If EOHHS determines that the Contractor's reports are incomplete or late, the Contractor shall implement a corrective action approved by EOHHS to correct the deficiencies. EOHHS may impose daily financial penalties until the Contractor's deficiencies are corrected.

EOHHS RESPONSIBILITIES

Administrative Responsibilities

EOHHS shall:

Designate a Contract Manager for the PCC Plan's BHP, who shall act as liaison, coordinate all requests and activities between the Contractor and EOHHS, and between the Contractor and the other state agencies involved with or affected by the Contract, for the duration of the Contract. EOHHS may change its designation of Contract Manager at any time during the Contract, and shall provide the Contractor with notification of any such change. The Contract Manager shall represent EOHHS in all programmatic and operational aspects of the Contract.

Provide the Contractor with available information and data in its possession necessary for successful performance of the Contract.

Furnish the Contractor with copies of EOHHS regulations, policies and procedures that may materially affect the Contractor's performance of its contractual obligations.

Notify the Contractor of any changes to the PCC Plan and other EOHHS programs, regulations, policies and procedures, operations or systems that may materially affect the Contractor's performance of its contractual obligations.

At least three months in advance, notify the Contractor of the Contract requirements on which EOHHS will base its annual review of the Contractor's performance.

Review and approve all materials, policies and procedures developed by the Contractor when such review and approval is required by the Contract.

Review the Contractor's submitted reports and reserve the right to request additional reports.

Meet with the Contractor's representative(s) on a routine basis, as either party deems necessary.

At its discretion, attend meetings or other activities conducted by the Contractor.

At any time during the term of the Contract, as appropriate, initiate negotiations with the Contractor to revise the scope of the Contract to meet EOHHS's needs.

Review any Contractor-proposed revisions to the scope of the Contract and approve, reject or modify the Contractor's proposal.

Pay the Contractor in accordance with **Section 10** of the Contract.

At its discretion, attend Provider site visits conducted by the Contractor.

Inform the Contractor of new PCCs to be included in MSS activities.

Contract Readiness Review

Prior to the Service Start Date, EOHHS will conduct a Readiness Review of the Contractor.

EOHHS will conduct a Readiness Review of the Contactor that may include on-site review. This review shall include, but is not limited to the elements described in **Section 2.1.D**, and shall be conducted no later than 60 days prior to enrollment of Covered Individuals into the Contractor's Plan, and at other times during the Contract period at the discretion of EOHHS.

EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional Readiness Review in the event that additional populations become managed care eligible.

EOHHS will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its discretion, allow the Contractor to propose a plan to remedy all deficiencies prior to the Service Start Date. Alternatively, EOHHS may, in its discretion, postpone the Service Start Date if the Contractor fails to satisfy all Readiness Review requirements

If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Service Start Date, and EOHHS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

Enrollment and Disenrollment

EOHHS shall, as appropriate, enroll, disenroll and re-enroll Covered Individuals in the BHP. EOHHS shall:

Inform the Contractor of the enrollment disenrollment, or re-enrollment through nightly transmissions of data from MMIS. The Contractor shall accept all Covered Individuals enrolled or re-enrolled by EOHHS.

At its discretion, and as appropriate, instruct the Contractor to resolve enrollment discrepancies through a manual system approved by EOHHS.

EOHHS shall:

Maintain the sole responsibility for the enrollment of Covered Individuals into the PCC Plan's BH Program, as described in this **Section 12.3**. The Contractor shall accept all Covered Individuals enrolled or re-enrolled by EOHHS.

On each business day of the Contract Year, make available to the Contractor, via the HIPAA 834 Outbound Daily Enrollment file, information pertaining to

all enrollments, including the Effective Date of Enrollment, which will be updated on a daily (business day) basis.

At its discretion, and as appropriate, instruct the Contractor to resolve enrollment discrepancies through a manual system approved by EOHHS.

At its discretion, automatically re-enroll on a prospective basis into the PCC Plan's BH Program any Covered Individuals who were disenrolled due to loss of eligibility and whose eligibility was re-established by EOHHS.

EOHHS shall disenroll a Covered Individual from the Contractor's program and he or she shall no longer be eligible for services following:

a. Loss of MassHealth eligibility;
b. Completion of the Enrollee's voluntary disenrollment request; or
c. Loss of eligibility for MassHealth Managed Care.

Except as otherwise provided under federal law or waiver, an Enrollee may disenroll voluntarily at any time. Such voluntary disenrollments shall take effect one business day after such request.

Make best efforts to provide the Contractor with the most current demographic information available to EOHHS. Such demographics shall include, when available to EOHHS, the Covered Individual's name address, MassHealth identification number, date of birth, telephone number, race, gender, ethnicity and primary language.

Review and respond to written complaints from the Contractor about EOHHS's Customer Services vendor or such vendor's subcontractors, or EOHHS's contracted Enrollment Broker within a reasonable time. EOHHS may request additional information from the Contractor in order to perform such review.

EOHHS may at its discretion develop and implement in consultation with the Contractor necessary processes and procedures required to implement enrollment of additional groups with the Contractor. If it does so, EOHHS shall:

Develop a benefit package for any such new group.

Inform the Contractor regarding demographic characteristics and utilization experience of any new group prior to initiation of enrollment, to the extent that such information is available.

Develop a Base PMPM Capitation Rate(s) for such group(s) consistent with 42 CFR 447.361 or other applicable federal statute and regulations, including with respect to UPL limitations, and in consultation with the Contractor.

Develop in cooperation with the Contractor an implementation strategy for providing services to new groups.

Information Systems

EOHHS shall:

Cooperate with the Contractor on any system implementation or enhancement necessary to meet the requirements of the Contract that affects either EOHHS's MMIS or the Contractor's MIS through the term of the Contract.

Provide technical assistance as necessary for the Contractor to gain access to specified EOHHS systems where such access is required by the Contract.

Provide and maintain a list of access codes for all Contractor staff requiring access to EOHHS systems.

Assist the Contractor, as necessary, to verify a Covered Individual's eligibility status in the BHP.

Performance Evaluation

EOHHS shall:

On a semiannual basis, conduct a "lessons learned" exercise with the Contractor. The results shall be used by EOHHS and the Contractor to improve and refine performance as it relates to the responsibilities of this Contract.

At its discretion, perform periodic programmatic and financial reviews. These may include on-site inspections and audits, by EOHHS or its agent, of the records of the Contractor and Network Providers.

Provide reasonable notice to the Contractor prior to any on-site visit to conduct an audit, and further notify the Contractor of any records EOHHS wishes to review.

On a semiannual basis and at its discretion, evaluate and score the Contractor's performance of all contractual obligations and its compliance with the terms of the Contract using an evaluation form such as the Performance Management Evaluation Form found in **Appendix I**.

Inform the Contractor of the results of any performance evaluations and of any dissatisfaction with the Contractor's performance, and reserve the right to demand a corrective action plan as set forth in **Section 13.17**, or to apply one or more of the sanctions provided in **Section 13.18**, including termination of the Contract in accordance with **Section 13.16**.

ADDITIONAL TERMS AND CONDITIONS

Prohibited Affiliations and Exclusion of Entities

In accordance with 42 U.S.C. § 1396u-2(d)(1) and 42 CFR 438.610, the Contractor shall not knowingly have an employment, consulting or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under the Contract with any person, or affiliate of such person, who is debarred, suspended or otherwise excluded under federal law, regulation, executive order or guidelines from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than 5 percent of the Contractor's equity nor be permitted to serve as a director, officer or partner of the Contractor. Any person who is an owner, employee, consultant, or has a contract with the Contractor shall:

Not have any direct or indirect financial interest with such entity; and

Not have been directly excluded from participation in the program under Titles XVIII or XIX of the Social Security Act, or debarred by any federal agency, or subject to a civil monetary penalty under the Social Security Act.

Disclosure Requirements

The Contractor shall within one business day disclose to EOHHS any non-compliance by the Contractor with any provision of this Contract, or any state or federal law or regulation governing this Contract.

The Contractor shall make the following federally required disclosures in accordance with 42. CFR § 455.100-106, 42 CFR 455.436, 42 CFR 1002.3. and 42 U.S.C. § 1396b(m)(4)(A) in the form and format specified by EOHHS, at any time upon a written request by EOHHS, and as follows:

Ownership and Control

Upon execution, renewal or extension of this Contract and within 35 days of any change in ownership, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.104 regarding ownership and control, including information about managing employees, agents, and persons who exercise operational or managerial control over the disclosing entity.

Business Transactions

Within 35 days of a written request by EOHHS, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.105 regarding business transactions.

Criminal Convictions

Upon any renewal or extension of this Contract and at any time upon a written request by EOHHS, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.106 regarding persons convicted of crimes.

Other Disclosures

The Contractor shall comply with all reporting and disclosure requirements of 41 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act.

The Contractor shall ensure that its Network Provider enrollment forms require Provider applicants to disclose complete ownership, control, and relationship information, and that Network Applicants and Network Providers fully and accurately complete the required portions of the EOHHS form developed for such purpose. Further, the Contractor shall require persons with an ownership or control interest, or persons who are agents or managing employees of Network Providers, to utilize the EOHHS form developed for such purpose to fully and accurately disclose health care-related criminal convictions, and to notify EOHHS of such disclosures within 20 working days.

Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in **Sections 13.2.B.1-3** and **13.2.C**, the Contractor shall fully and accurately complete the EOHHS form developed for such purpose, the current version of which is attached hereto as **Appendix B-4**. EOHHS may update or replace this Appendix without the need for a Contract amendment.

The Contractor shall search the federal HHS-OIG's List of Excluded Individuals/Entities (LEIE) and theSystem Award Management website for the names of Network providers upon enrollment, reenrollment, credentialing or re-credentialing, as further described in **Section 3.1.I**. In addition, the Contractor shall conduct such searches for the names of Network providers, persons with ownership or control interest in the Contractor, and agents or managing employees of the Contractor at least monthly to ensure that EOHHS does not pay for services provided by excluded persons or entities.

EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section 13.2** or in response to the information contained in the Contractor's disclosures under this **Section 13.2**. In addition, the Contractor shall not be entitled to payment for any MassHealth services for which EOHHS determines federal reimbursement is not available. Any such payments shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238, et seq. to impose sanctions.

EOHHS's Option to Amend or Modify Scope of Work

EOHHS shall have the option at its sole discretion to modify, reduce or terminate any activity related to the Contract whenever, in the judgment of EOHHS, the goals of the project have been modified or altered in any way that necessitates such changes. In the event of the reduction of the scope of work for any tasks or portions thereof, EOHHS will

provide written notice to the Contractor. In the event of a change in the scope of work of any tasks or portions thereof, EOHHS will initiate negotiations with the Contractor.

Notwithstanding the generality of the foregoing, EOHHS reserves the right to amend the Contract to implement new initiatives or to modify initiatives related to:

new MassHealth programs;

expansion of or changes to existing MassHealth programs;

other programs as specified by EOHHS;

programs resulting from state or federal legislation, including but not limited to the Patient Protection and Affordable Care Act (ACA) of 2010 (Public Law 111–148 March 23, 2010), regulations, initiatives, or judicial decisions that may affect in whole or in part any components of the PCC Plan or the BHP;

requiring or allowing individuals age 65 and over, with or without Medicare and individuals age 21 or over with Medicare to enroll in the PCC Plan or the BHP; and

changes the managed care options available to any or all MassHealth Coverage Types, in whole or in part, including, but limited to, requiring MassHealth Coverage Type(s) to choose among Managed Care Organizations (MCOs), requiring MassHealth Coverage Types to enroll in the PCC Plan and excluding any or all MassHealth Coverage Types from either mandatory or voluntary Managed Care.

The parties shall negotiate in good faith to implement any such initiatives proposed by EOHHS. The Contractor's responsibilities, including staffing, space, and all other budgetary requirements, are subject to change due to implementation of such initiatives. EOHHS reserves the right to modify the Contract, including the budget and reimbursements, due to program modifications. In addition, the Contractor may request an opportunity to enter into negotiations with EOHHS over amendments to the Contract related to new initiatives or modified initiatives as described in this section. EOHHS may grant such a request in its sole discretion.

EOHHS reserves the right to enroll additional MassHealth Members over the term of the Contract, or to reduce current enrollment levels. Possible EOHHS initiatives that could change enrollment include but are not limited to:

Increased or decreased MassHealth membership pursuant to any MassHealth waiver;

Expanded eligibility coverage for children under age 19 or adults over 65;

Any other state or federal changes that result in an increase or decrease in MassHealth-eligible individuals, including changes to comply with the ACA, such as an adjustment to the minimum federal poverty eligibility

level, or a change in the MassHealth Managed Care enrollment policy or criteria for participation; and

Changes in EOHHS's methodology by which assignments are made to MassHealth Managed Care plans.

The Contractor shall propose to EOHHS for approval during the term of the Contract new initiatives and reimbursement mechanisms designed to further integrate PCC Plan administrative functions with BH management and performance. Such proposals shall include, upon EOHHS request, detailed work plans and timelines. EOHHS may at its sole discretion accept, reject or modify any proposed initiative.

Contract Compliance

The Contractor shall immediately notify EOHHS of any occurrence that affects the Contractor's ability to operate and comply with all or any material part of its responsibilities under the Contract, along with an assessment of the time and effort necessary to recover.

Compliance with Laws

The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, the Contractor shall comply with Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act; Titles XIX and XXI of the Social Security Act and waivers thereof; Chapter 141 of the Acts of 2000 and applicable regulations; Chapter 58 of the Acts of 2006 and applicable regulations; 42 CFR Part 438; The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (commonly referred to as the Mental Health Parity Law) and applicable regulations; and relevant provisions of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, to the extent such provisions apply and other laws regarding privacy and confidentiality.

The Contractor shall promptly execute and comply with any amendment to this Contract that EOHHS determines is necessary to ensure compliance with all applicable federal and state statutes and regulations and any federal waivers including, without limitation, those provisions cited in this Contract, and the terms and conditions of EOHHS's Research and Development Waiver under Section 1115 of the Social Security Act, including any revisions to such waiver.

The Contractor shall be liable for any and all loss of Federal Financial Participation (FFP) incurred by the Commonwealth that results from the Contractor's failure to comply with any requirement of federal law or regulation.

Internal Quality Controls

The Contractor shall:

Comply with Office of State Comptroller (OSC) and the Committee of Sponsoring Organization (COSO) Internal Control Standards.

Have in place a process for investigating and resolving any EOHHS dissatisfaction with the Contractor's performance and for improvements in its internal systems.

Maintain internal quality standards, indicators and written procedures to ensure accurate, timely, and consistent Contract activities to promote:

- Adherence to Contract deadlines for the submission of accurate and timely reports and other materials;
- Accurate and consistent dissemination of oral and written information by Contractor staff;
- Accurate, clear documentation of the Contractor's activities (programmatic and financial) required by EOHHS;
- Data integrity and confidentially of the Contractor's MIS, including maintenance of history files; and
- Any other EOHHS-specified operational and reporting performance criteria.

Monitor internal quality control measures, standards, and procedures on a continuous basis and update them as needed to keep them current with standards.

Report to EOHHS in writing all internal quality control issues and findings when and if they arise.

Loss of Licensure

The Contractor shall report to EOHHS if at any time during the Contract the Contractor or any material subcontractor loses, or is at risk of losing, any applicable license, state approval or accreditation. Such loss may be grounds for termination of the Contract under the provisions of **Section 13.16**.

Leases and Licensing of Software

The Contractor shall:

Incorporate into all software license agreements a provision that the Contractor is permitted to assign the license to EOHHS or to EOHHS's designee at no cost to EOHHS. However, in the event that the Contractor is unable to obtain such assignment provision, the Contractor shall obtain the written authorization of EOHHS prior to entering into the agreement. This requirement does not extend to commercially available software for which EOHHS may readily obtain its own license. All payments to maintain the lease, rental agreement, or license that become due after the termination of the agreement become the responsibility of EOHHS or EOHHS's designee. Upon termination of the Contract for any reason, the Contractor hereby agrees to assign or otherwise transfer any

such lease, rental agreement or software license agreement to EOHHS or its designee, at no cost to EOHHS, upon EOHHS's request.

The Contractor agrees that, except with respect to commercial off-the-shelf software (COTS), EOHHS shall be granted a royalty-free, non-exclusive, perpetual and irrevocable license to the use of all software used by the Contractor in the performance of its obligations under the Contract.

Transfer to EOHHS or EOHHS's designee all applications designed or operated under the Contract at no cost to EOHHS, and to provide user and system documentation for any software developed by the Contractor for EOHHS. Upon EOHHS's written request, within 30 calendar days, the Contractor shall deliver to EOHHS, or its designee(s), all software to which the Commonwealth has sole, joint, or several proprietary ownership rights including, without limitation, all code and all documentation of software, as generated by the Contractor and utilized by the Contractor to fulfill its responsibilities in this Contract.

Other Contracts

Upon EOHHS request, the Contractor shall provide a complete list of any managed behavioral health care contracts it or its corporate parent or subsidiary holds within Massachusetts in addition to this Contract. EOHHS shall not disclose non-public information that the Contractor may consider proprietary, except as required by law.

Counterparts

The Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

Entire Contract

The Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations and undertakings not set forth or incorporated herein. The terms of the Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein.

Correction of Omissions, Ambiguities, and Manifest Errors

The Contractor shall negotiate in good faith with EOHHS to cure any omissions, ambiguities, or manifest errors in the Contract. By mutual agreement, the Contractor and EOHHS may amend the Contract where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by both parties, and attached to the Contract.

No Third-Party Enforcement

This Contract is entered into by and between the parties hereto and for their sole benefit. There is no intent by either party to create or establish a third-party beneficiary status, or to create any rights in or confer any benefits upon any person or entity not a party to this Contract (except for such rights as are expressly created and set forth in this Contract). Except for the foregoing, no third party shall have any right to enforce or to enjoy any benefit or obligation created or established under this Contract.

Responsibility of the Contractor

The Contractor shall:

Ensure the professional quality, technical accuracy and timely completion and delivery of all services furnished by the Contractor under the Contract.

Without additional compensation, correct or revise any errors, omissions or other deficiencies in its deliverables and other services.

The approval of services furnished hereunder shall not in any way relieve the Contractor of responsibility for the technical adequacy of its work. The review, approval, acceptance of or payment for any of the services rendered shall not be construed as a waiver of any of EOHHS's rights under the Contract or of any cause of action arising out of the performance of the Contract.

Contract Term

The Contract is anticipated to be effective for the period from October 1, 2012, through June 30, 2017, unless otherwise terminated or extended in accordance with this section or at such other time that EOHHS may implement changes that render the performance of the Contract unnecessary. At EOHHS's option, the Contract may be extended for up to five additional years at the discretion of EOHHS, and in increments and upon terms to be negotiated by the parties.

Contract Year Two begins on November 15, 2013, and ends on June 30, 2014.

Termination

Termination without Prior Notice

EOHHS may terminate the Contract immediately and without prior written notice, upon any of the following events:

The Contractor's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property.

The Contractor's admission in writing that it is unable to pay its debts as they mature.

The Contractor's assignment for the benefit of creditors.

Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or

answer admitting the material allegations of a petition filed against the Contractor in any such proceeding.

Commencement of an involuntary proceeding against the Contractor or Material Subcontractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within 60 days.

The Contractor loses any applicable state approval.

Cessation in whole or in part of state or federal funding for or approval of the Contract.

EOHHS determines in its sole discretion that the health, safety or welfare of its Covered Individuals requires immediate termination of the Contract.

The Contractor is non-compliant with **Section 13.1**, and the Secretary of Health and Human Services, in accordance with 42 CFR 438.610(c), directs EOHHS to terminate, or does not permit EOHHS to extend, renew or otherwise continue this Contract.

The Contractor is non-compliant with **Section 13.2**.

Termination with Prior Notice

Either party may terminate the Contract upon breach by a party of any duty or obligation hereunder, which breach continues unremedied for 30 days after written notice thereof by the other party.

EOHHS may terminate the Contract after written notice thereof to the Contractor in the event the Contractor fails to accept EOHHS's proposed offer of payment for any financial provision identified in **Section 10** of this Contract.

EOHHS may terminate the Contract if the EOHHS determines that state or federal health care reform initiatives or state or federal health care cost containment initiative makes termination of the Contract necessary or advisable as determined by EOHHS

Termination with Prior Notice for Violation of Section 14 of the Contract

Notwithstanding any other provision in the Contract, EOHHS may terminate this Contract immediately, upon written notice, if EOHHS determines, in its sole discretion, that the Contractor has materially breached any of its obligations set forth in **Section 14**, or any other provision of the Contract pertaining to the security and privacy of any Protected Health Information (PHI) or any data provided to the Contractor under this Contract.

In the event that termination of this Contract for a material breach of any obligation regarding PHI is not feasible, or if a cure is not feasible, EOHHS shall report such breach or violation to the U.S. Secretary of Health and Human Services.

Effect of Termination for Violation of Section 14

Upon termination of the Contract for any reason whatsoever, the Contractor shall return or destroy all PHI and any other Personal Data obtained or created in any form under the Contract, and the Contractor shall not retain any copies of such data in any form. This provision shall apply to all PHI and data in the possession of the Contractor's subcontractors or agents, and the Contractor shall ensure that all such data in the possession of its subcontractors or agents has been returned or destroyed and that no subcontractor or agent retains any copies of such data in any form.

Notwithstanding any other provision concerning the term of this Contract, all protections pertaining to any PHI or other data covered by the Contract shall continue to apply until such time as all such data is returned to EOHHS or destroyed.

Continued Obligations

In the event of termination, expiration or non-renewal of the Contract, the obligations of the parties hereunder with regard to each Covered Individual at the time of termination, expiration, or non-renewal shall continue until the Covered Individual has been disenrolled; provided, however, that EOHHS shall exercise best efforts to complete all disenrollment activities within six months from the date of termination, expiration or non-renewal.

In the event that the Contract is terminated, expires, or is not renewed for any reason:

EOHHS shall be responsible for notifying all Covered Individuals covered by this Contract of the date of termination and the process by which they will continue to receive medical care;

The Contractor shall promptly return to EOHHS all payments advanced to the Contractor for coverage of Covered Individuals for periods after the effective date of their disenrollment; and

The Contractor shall supply to EOHHS all information necessary for the reimbursement of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims shall be paid to the Contractor accordingly.

For expiration or non-renewal of the Contract following a reprocurement of the PCC Plan's BH Program, the financial terms in effect for the current Contract Year shall remain in effect until all Covered Individuals have been disenrolled, except that there shall be no Performance Incentives in EOHHS's sole discretion.

Corrective Action Plan

If, at any time, EOHHS determines that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a

corrective action plan to correct such deficiency. EOHHS shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor shall, upon approval of EOHHS, immediately implement the corrective action plan, as approved or modified by EOHHS. The Contractor's failure to implement any corrective action plan may, in the sole discretion of EOHHS, be considered breach of Contract, subject to any and all contractual remedies including: those under the Contractor's Performance Guarantees in accordance with **Appendix H-2**; termination of the Contract with or without notice; or other intermediate sanctions as described in **Section 13.18**.

Intermediate Sanctions

In addition to termination under **Section 13.16**, EOHHS may, in its sole discretion, impose any or all of the sanctions in subsection B below, for any of the circumstances described in this subsection A. EOHHS shall only impose those sanctions it determines to be reasonable and appropriate for the specific violation(s) identified. Sanctions may be imposed if the Contractor:

Fails to provide Medically Necessary Covered Services required under the Contract to Covered Individuals and Uninsured Individuals including persons covered by Medicare only;

Imposes premiums or other charges on Covered Individuals and Uninsured Individuals including persons covered by Medicare only in excess of any permitted under the Contract;

Discriminates against Covered Individuals on the basis of race, color, gender, or national origin;

Misrepresents or falsifies information provided to EOHHS, the U.S. Department of Health and Human Services, Covered Individuals, Providers or PCCs;

Fails to comply with applicable federal requirements regarding Provider incentive plans;

Fails to comply with federal or state statutory or regulatory requirements related to the Contract;

Violates restrictions or other requirements regarding marketing;

Fails to comply with any corrective action plan required by EOHHS

Fails to meet deliverable timelines which deliverables shall include those reports, analyses, workplans, surveys, evaluations, metrics and other documents with submission dates explicitly defined in the Contract or, if a date is not specified, with explicit timelines or bases of specified duration provided therein'

Fails to meet satisfactory performance based upon EOHHS' Performance Management Evaluation, in accordance with the provisions of **Section 12.5.D**;

Fails to comply with financial solvency requirements;

Fails to comply, as determined by EOHHS from audit findings, with any provision of this Contract related to DSRAs;

Fails to comply with any other requirement of Section 1932 of the Social Security Act, and any implementing regulations; or

Fails to comply with any other requirements of this Contract.

Such sanctions may include without limitation, any or all of the following:

financial penalties, including without limitation asserting EOHHS's rights under its Performance Guarantee, in accordance with the provisions of **Appendix H-2**;

withholding of administrative payments;

withholding Performance Incentive bonuses;

the appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396u-2(e)(2)(B);

suspension of payment to the Contractor; adjusting or withholding Estimated Base Capitation Rate Payments or other Base PMPM Capitation Rate payments;

adjusting or withholding of Service Compensation Payments;

adjusting or withholding the DMH Administrative Compensation Rate or Administrative Component of the MassHealth Capitation Payments; and

withholding gain from any risk-sharing arrangement.

For any Contract responsibilities for which the Contractor utilizes a Material Subcontractor, if EOHHS identifies any deficiency attributable to the Material Subcontractor in the Contractor's performance for which the Contractor has not successfully implemented an approved corrective action plan in accordance with this **Section 13.17**, EOHHS may require the Contractor to terminate its agreement with the Material Subcontractor and subcontract with a Material Subcontractor deemed satisfactory by EOHHS, or to otherwise alter the manner or method in which the Contractor performs those responsibilities.

The intermediate sanctions provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

Authorizations

This Contract is subject to all necessary federal and state approvals.

Medical Records

The Contractor shall:

Comply with, and require Network Providers to comply with, all state and federal statutory and regulatory requirements applicable to medical records, including the requirements set

forth in 130 CMR 130 CMR 433.409, 130 CMR 450.205, 42 CFR 456.111 and 42 CFR 456.21 (if applicable), and any amendments thereto. In addition, the Contractor shall require that all medical records maintained by it or its Network Providers shall, at a minimum:

Be maintained in a manner that is current, detailed, and organized and that permits effective patient care and quality review;

Include sufficient information to identify the Covered Individual, date of encounter and pertinent information that documents the Covered Individual's diagnosis;

Describe the appropriateness of the treatment and services, the course and results of the treatment and services; and

Accurately document the following:

Covered Individual identifying information;

clinical information;

Behavioral Health Clinical Assessments;

treatment plans;

treatment or services provided;

contacts with Covered Individuals' family, guardians, or significant others; and

treatment outcomes.

Comply with, and require Network Providers to comply with, all state and federal statutory and regulatory requirements applicable to confidentiality of medical records, including but not limited to M.G.L. c. 66A and, if applicable, M.G.L. c. 123 § 36, 104 CMR 27.17, and 104 CMR 28.09.

Provide EOHHS with a copy of any Covered Individual's medical records, in general within 10 days of EOHHS's request; except that EOHHS may allow the Contractor up to one month from the date of EOHHS's initial request to produce such records if the Contractor has made best efforts to produce them in the specified time and EOHHS reasonably determines that the need for such record(s) is not urgent.

Conduct medical record audits periodically and at the request of EOHHS. Such audits may be subject to validation by EOHHS or its agent.

Record Retention

The Contractor is responsible for maintaining all Contract financial and programmatic records specified by EOHHS in accordance with the requirements of 45 CFR 74.53 and Section 7 of the Commonwealth's Standard Terms and Conditions. Specifically, the Contractor shall:

Maintain all pertinent records in a cost-effective and easily retrievable format.

Maintain an off-site storage facility for EOHHS-specified records that is outside the disaster range of the Contractor's principal place of business as described in **Section 2.2.B** and that meets recognized industry standards for physical and environmental security.

Take all reasonable and necessary steps to protect the physical security of any personal data or other EOHHS data and materials used by the Contractor. The protection of physical security shall mean prevention of unauthorized access, dissemination, misuse, reproduction, removal or damage to data or materials used by or in the possession of the Contractor.

Immediately notify EOHHS, both orally and in writing and before releasing any relevant data or materials, if:

Access to or copies of personal or EOHHS data are requested through public records law request or subpoena; or

The Contractor has reason at any time to believe that any data applicable to the Contract have been improperly accessed, disseminated, misused, copied or removed.

Research Data

The Contractor shall obtain written authorization from EOHHS for the use of any data pertaining to the Contract, for research or any other purposes, prior to releasing any information.

Information Sharing

The Contractor shall arrange for the transfer, at no cost to EOHHS or the Covered Individual, of BH and medical information regarding such Covered Individual or Uninsured Individual to any subsequent provider of BH and/or medical services, subject to all applicable federal and state laws, as may be requested by the Covered Individual, Provider, or directed by EOHHS, regulatory agencies of the Commonwealth or the United States government. With respect to Covered Individuals who are Children in the Care and/or Custody of the Commonwealth, the Contractor shall provide in a timely manner, upon reasonable request of the state agency with custody of the Covered Individuals, a copy of any BH or medical records in the Contractor's possession.

Protection of Covered Individual-Provider Communications

In accordance with 42 U.S.C. § 1396u-2(b)(3) and 42 CFR 438.102, the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a Covered Individual who is his or her patient, for the following:

The Covered Individual's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

Any information the Covered Individual needs in order to decide among all relevant treatment options;

The risks, benefits, and consequences of treatment or non-treatment; and

The Covered Individual's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Notwithstanding the provisions of subsection A, and subject to the requirements set forth in subsections B and C, the Contractor is not required to provide, reimburse for, or provide coverage of, counseling or referral service if the Contractor objects to the service on moral or religious grounds. The Contractor must furnish information about any service the Contractor does not cover due to moral or religious grounds as follows:

To EOHHS: at least 60 days prior to adopting the policy during the term of the Contract; and

To Covered Individuals: at least 30 days prior to adopting the policy during the term of the Contract.

The Contractor shall accept a reduction in the Base PMPM Capitation Rate for any service it does not provide, reimburse for, or provide coverage of due to moral or religious grounds.

Recordkeeping, Audit and Inspection of Records

The Contractor shall maintain books, records and other compilations of data pertaining to the performance of the provisions and requirements of the Contract to the extent and in such detail as shall properly substantiate claims for payment under the Contract. All such records shall be kept for a minimum period of six years.

EOHHS, the Governor, the Secretary of Administration and Finance, the Comptroller, the State Auditor, the Attorney General and CMS, or any of their duly authorized representatives or designees shall have the right at reasonable times and upon reasonable notice to examine and copy the books, records and other compilations of data of the Contractor which pertain to the provisions and requirements of this Contract, and to evaluate through inspection or other means the quality, appropriateness and timeliness of services performed by the Contractor under the Contract.

EOHHS, the Governor, the Secretary of Administration and Finance, the Comptroller, the State Auditor, the Attorney General, the U.S. Department of Health and Human Services, and CMS, or any of their duly authorized representatives or designees shall have the right at reasonable times and upon reasonable notice to inspect and audit the financial records of the Contractor and its subcontractors.

Assignment

The Contractor shall not assign or transfer any right or interest in the Contract to any successor entity or other entity without the prior written consent of EOHHS.

Subcontractors, Employees, and Agents

The Contractor shall ensure that its employees, subcontractors, and any other of its agents in the performance of the Contract act in an independent capacity, and not as officers or employees of EOHHS or the Commonwealth of Massachusetts.

Use and Ownership of Data and Software

EOHHS Rights

All data developed or acquired by the Contractor from EOHHS or from others in the performance of the Contract (including personal data) remain the property of EOHHS. EOHHS shall be given free and full access at all reasonable times to all such data. All finished or unfinished studies, analyses, flow charts, magnetic tapes, design documents, program specifications, programs, computer source codings and listings, test data, test results, schedules and planning documents, training materials and user manuals, forms, reports, and any other documentation and software, including modifications thereto, prepared, acquired, designed, improved or developed by the Contractor for delivery to EOHHS under the Contract shall be and remain the property of EOHHS. Federal agencies providing full or partial funding for documentation and software pursuant to this Contract shall have royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use and authorize others to use all such documentation and software.

Contractor Limitations

The Contractor shall:

Not disseminate, reproduce, display or publish any report, map, information, data or other materials or documents produced in whole or in part pursuant to the Contract without the prior written consent of EOHHS, nor shall any such report, map, information, data or other materials or documents be the subject of an application for patent or copyright by or on behalf of the Contractor without the prior written consent of EOHHS.

Use EOHHS-owned data, materials and documents, before or after termination or expiration of the Contract, only as required for the performance of the Contract.

Return to EOHHS promptly, but in any event no later than one week after EOHHS's request, EOHHS-owned or Commonwealth-owned data, materials and documents, in whatever form they are maintained by the Contractor.

Ownership of Furnishings and Equipment

Unless EOHHS instructs otherwise, the Contractor shall provide and retain all furnishings and equipment used in the completion of its performance under this Contract.

Indemnification

The Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with the Contractor's violation of any federal or state law or regulation or any negligent action or inaction or willful misconduct of the Contractor, or any person employed by the Contractor, provided that:

The Contractor is notified of any claims made directly to EOHHS within a reasonable time from when EOHHS becomes aware of the claim; and

The Contractor is afforded an opportunity to participate in the defense of such claims.

Prohibition against Discrimination

In accordance with 42 U.S.C. § 1396u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any Network Provider who is acting within the scope of the Network Provider's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reasons for its decision. This section shall not be construed to prohibit the Contractor from including Network Providers only to the extent necessary to meet the needs of Covered Individuals or from using different reimbursement for different Network Providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

The Contractor shall not discriminate and will not use any policy or practice that has the effect of discriminating against any individual receiving service through this Contract, on the basis of health status, need for health care, race, color or national origin.

If a complaint or claim against the Contractor is presented to the MCAD, the Contractor shall cooperate with MCAD in the investigation and disposition of such complaint or claim.

Anti-Boycott Covenant

The Contractor shall ensure that during the time the Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, participate in or cooperate with an international boycott as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E § 2. Without limiting such other rights as it may have, EOHHS shall be entitled to rescind the Contract in the event of noncompliance with this section. As used herein, an affiliated company shall be any business entity directly or indirectly owning at least 51 percent of the ownership interests of the Contractor.

Public Communications Protocol

The Contractor shall obtain prior approval from EOHHS before the Contractor or any of its officers, agents, employees or subcontractors respond to any media inquiry, make any public comment or issue other public communication regarding any aspect of the Contract.

Advance Directives

If applicable, the Contractor shall comply with (1) the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives; and (2) the requirements of 130 CMR 450.112 and 42 CFR 438.6(i). If applicable, the Contractor shall provide adult Enrollees with written information on advance directives policies, including a description of applicable state law. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

Insurance for Contractor's Employees

The Contractor shall maintain at its expense all insurance required by law for its employees, including but not limited to worker's compensation unemployment compensation, and health insurance, as applicable, and shall provide EOHHS with certification of same prior to the Service Start Date and by September 30 of each subsequent year.

Disaster Recovery and Continuity of Operations Plan

The Contractor shall:

Develop, submit to EOHHS for approval no later than four months following the Service Start Date, and maintain a disaster recovery plan that meets recognized industry standards and federal requirements for security, disaster range, and disaster recovery requirements.

Ensure that the Contractor's responsibilities under the Contract are never interrupted for the delivery of BH Covered Services, and are not interrupted for more than five business days for all other functions.

Maintain a continuity of operations plan (COOP) that addresses how the Contractor's, Material Subcontractors', and other subcontractors' operations shall be maintained in the event of a natural disaster, terrorist attack, pandemic or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities. The Contractor shall provide copies of such plan to EOHHS upon request and shall inform EOHHS whenever such plan must be implemented.

Use reasonable care to minimize the likelihood of all damage, loss of data, delays, and errors resulting from an uncontrollable event.

Store a copy of the disaster recovery plan.

Prepare a summary of the disaster recovery plan to communicate the procedures under the plan to EOHHS and all Contractor employees.

Review and, if necessary, update the disaster recovery plan on an annual basis and whenever the Contractor or EOHHS makes changes to systems and/or business operations that warrant updating the plan; resubmit any such updated plan to EOHHS for approval.

Test the disaster recovery plan on an annual basis or whenever there have been substantial changes to the plan.

Participate in disaster recovery tests conducted by EOHHS or the Massachusetts Information Technology Department to test connections from the Contractor's facilities to the backup data center facility identified in **Section 2.2.B**.

License of Software

The Contractor agrees that, except with respect to commercial off-the-shelf software (COTS), EOHHS shall be granted a royalty-free, non-exclusive, perpetual and irrevocable license to the use of all software used by the Contractor in the performance of its obligations under the Contract.

Order of Precedence

The Contractor's response to EOHHS's Request for Responses (RFR) that served as the basis for this Contract is incorporated by reference into the Contract. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

this Contract, including any amendments thereto;

the Contractor's response submitted on August 9, 2011; and

EOHHS's Request for Responses for a Vendor to Provide for the MassHealth Primary Care Clinician Plan a Comprehensive Behavioral Health Program and Management Support Services, as well as Behavioral Health Specialty Programs, issued on May 18, 2011, including any amendments thereto.

Section Headings

The headings of the sections of the Contract are for convenience only and do not affect the construction hereof.

Waiver

EOHHS's acceptance or approval of any materials, including those materials submitted in relation to the Contract, shall not constitute waiver of any requirements of the Contract.

Administrative Procedures Not Covered

EOHHS may from time to time issue memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters.

Effect of Invalidity of Clauses

If any clause or provision of the Contract is in conflict with any state or federal law or regulation, that clause or provision shall be null and void; any such invalidity shall not affect the validity of the remainder of the Contract.

Survival

The obligations of the Contractor under **Section 14** of this Contract shall survive the termination of the Contract.

Remedies

Nothing in this Contract shall be construed to waive or limit any of EOHHS's legal rights or remedies which may arise from Contractor's unauthorized use or disclosure of any data received by it under the Contract.

Interpretation

Any ambiguity in this Contract shall be resolved to permit EOHHS to comply with the Privacy Rule, HIPAA, and any other applicable law pertaining to the privacy, confidentiality, or security of PHI or Personal Data.

Written Notices

Notices to the parties as to any Contract matter will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand as follows:

To EOHHS:

Emily Sherwood
Director of the Office of Behavioral Health
Executive Office of Health and Human Services
1 Ashburton Place, 11th floor
Boston, MA 02108

With copies to:

General Counsel
Executive Office of Health and Human Services
1 Ashburton Place, 11th floor
Boston, MA 02108

Rashiem Grant, Contract Manager
Executive Office of Health and Human Services
Accounting Unit, 7th floor
600 Washington Street
Boston, MA 02111-1712

And, in addition, for notices required by the provisions of **Section 14**, a copy to:

EOHHS Privacy Office
600 Washington Street
Boston, MA 02111

To the Contractor:

PRIVACY AND CONFIDENTIALITY

Definitions

All terms used but not otherwise defined in this section shall be construed in a manner consistent with the Privacy and Security Rules and all other applicable state or federal privacy or security laws.

Commonwealth Security Information. "Commonwealth Security Information" shall mean all data that pertains to the security of the Commonwealth's information technology, specifically, information pertaining to the manner in which the Commonwealth protects its information technology systems against unauthorized access to or modification of information, whether in storage, processing or transit, and against the denial of service to authorized users, or the provision of service to authorized users, including those measures necessary to detect, document and counter such threats.

EOHHS-CE. "EOHHS-CE" shall mean any component of EOHHS and its constituent Agencies that constitutes a Covered Entity under the Privacy and Security Rules (including: the Office of Medicaid; the Department of Developmental Services; the Department of Mental Health; the Soldiers' Home in Massachusetts; the Soldiers' Home in Holyoke; the covered components of the Department of Public Health, a hybrid agency, having designated its covered components as: the Childhood Lead Screening Laboratory and the MDPH Public Health Hospitals (Lemuel Shattuck Hospital; Massachusetts Hospital School; Tewksbury Hospital; Western Massachusetts Hospital; and State Office of Pharmacy Services)) whose data is covered by this Contract.

Individual. "Individual" shall mean the person to whom the PI refers and shall include a person who qualifies as a personal representative in accord with 45 CFR § 164.502 (g).

Privacy Rule. "Privacy Rule" shall mean the Standards of Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164.

Protected Information (PI). "Protected Information" shall mean any "Personal Data" as defined in Mass. Gen. Laws c. 66A and any "Protected Health Information" as defined in the Privacy Rule; any "Patient Identifying Information" as defined in 42 CFR Part 2; and any other confidential individually identifiable information under any federal or state law (including for example any state and federal tax return information) that the Contractor uses, maintains, discloses, receives, creates or otherwise obtains under this Contract. Information, including aggregate information, is considered PI if it is not fully de-identified in accord with 45 CFR 164.514 (a), (b), and (c).

Required By Law. "Required By Law" shall have the same meaning as used in the Privacy Rule.

Secretary. "Secretary" shall mean the Secretary of the US Department of Health and Human Services or the Secretary's designee.

Security Incident. "Security Incident" shall have the same meaning as used in the Security Rule.

Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information, at 45 CFR Parts 160 and 164.

Contractor's Obligations

Mass. Gen. Laws c. 66A and other Privacy and Security Obligations

The Contractor acknowledges that in the performance of this Contract it will create, receive, use, disclose, maintain, or otherwise obtain "Personal Data," and that in so doing, it becomes a "Holder" of Personal Data, as such terms are used within Mass. Gen. Laws c. 66A. The Contractor agrees that, in a manner consistent with the Privacy and Security Rules, it shall comply with Mass. Gen. Laws c. 66A, and any other applicable privacy or security law (state or federal) governing Contractor's use, disclosure, and maintenance of any PI under this Contract, including but not limited to, 42 CFR Part 431, Subpart F; ; Mass. Gen. Laws c. 93H; 801 CMR § 3.00; 201 CMR 17; and Executive Order 504.

The Contractor further agrees that it shall comply with any other privacy and security obligation that is applicable to any PI under this Contract as the result of EOHHS having entered into an agreement with a third party (such as the Social Security Administration) to obtain the data, including by way of illustration and not limitation, signing any written compliance acknowledgment or confidentiality agreement or complying with any other privacy and security obligation required by the third party for access to data that EOHHS receives from the third party.

Business Associate

The Contractor acknowledges that in the performance of this Contract, it is the Business Associate of EOHHS, as that term is used in the Privacy and Security Rules for providing services pursuant to **Sections 4.4, 4.5, 5, 6, 7.1, 7.2, 7.3, 7.4**, and **Section 8** to the extent that **Section 8** activities involve functions performed by the Contractor on EOHHS' behalf, and such additional sections as EOHHS shall identify in the Contract or shall identify in either written amendments to the Contract or written work plans or instructions during the course of the Contract. The Contractor further acknowledges that Title XIII (the HITECH Act) of the American Recovery and Reinvestment Act of 2009 and related modifications to the Privacy and Security Rules issued by the federal Department of Health and Human Services on January 25, 2013 at 78 FR 5566 through 5702, with an effective date of March 26, 2013, increases the privacy and security obligations of, and imposes certain civil and criminal penalties upon, a Business Associate under the Health Insurance Portability and Accountability Act and the Privacy and Security Rules. Further, the HITECH Act imposes direct responsibility upon the Business Associate as if the Business Associate were a Covered Entity, as that term is

used in the Privacy and Security Rules, for certain obligations, including but not limited to the requirement to implement administrative, physical, and technical safeguards to protect PI and other requirements set forth in 45 CFR §§ 164.308, 164.310, 164.312, and 164.316. The HITECH Act also imposes certain breach notification obligations upon a Business Associate, and permits a Business Associate to use and disclose Protected Health Information, as that term is used in the Privacy and Security Rules, only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR 164.504(e). The Contractor agrees to comply with all Business Associate requirements implemented by the HITECH Act and related modifications to the Privacy and Security Rules in accord with any applicable compliance dates.

EOHHS Data

The Contractor acknowledges that its access to, receipt, creation, use, disclosure, and maintenance of any PI covered by this Contract, and any data derived or extracted from such PI, arises from and is defined by the Contractor's obligations under this Contract, and that the Contractor does not possess any independent rights of ownership to such data..

Agents and Subcontractors

The Contractor shall not engage any agent or subcontractor to perform any activity under this Contract involving PI, unless such engagement is otherwise explicitly permitted under this Contract or unless the Contractor first seeks EOHHS's written permission to engage an agent or subcontractor by submitting a written description of the work to be performed by the proposed agent or subcontractor together with such other information as EOHHS may request. If engaging an agent or subcontractor is permitted, the Contractor shall ensure that the agent or subcontractor agrees in writing to the same restrictions and conditions that apply to Contractor under this Contract with respect to PI, including but not limited to, implementing reasonable safeguards to protect such information and conformance to applicable laws including but not limited to: 45 CFR 160.103; 45 CFR 164.502(e)(l)(ii) and (2); and 45 CFR 164.504(e).

The Contractor shall ensure that its agents or subcontractors who (i) have access to personal information as defined in Mass. Gen. Law c. 93H, and personal data, as defined in Mass. Gen. Laws c. 66A, that the Contractor uses, maintains, receives, creates or otherwise obtains under this Contract, or (ii) have access to Contractor systems containing such information or data, sign an Executive Order 504 Contractor Certification Form or other written agreement containing all applicable data security obligations as required by such certification form. Upon EOHHS' request, Contractor shall provide EOHHS with a listing of its agents or subcontractors who have such access and copies of these certifications.

Contractor is solely responsible for its agents' and subcontractors' compliance with this provision and all requirements in this **Section 14**, and shall not be relieved of any obligation under this **Section 14** because the data was in the hands of its agents or subcontractors.

Data Security

Administrative, Physical, and Technical Safeguards

The Contractor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PI and that prevent use or disclosure of such data other than as provided for by this Contract. All such safeguards must meet, at a minimum, all standards set forth in the Privacy and Security Rules, as applicable to a business associate; all applicable standards set forth in **Section 9** of this Contract; and must comply with all security mechanisms and processes established for access to any of EOHHS's databases, as well as all Commonwealth security and information technology resource policies, processes, and mechanisms established for access to PI, including any applicable data security policies and procedures established by Executive Order 504 (for which the Contractor agrees to separately sign all required compliance certifications) and by the Information Technology Division. As one of its safeguards, the Contractor shall not transmit PI in non-secure transmissions over the Internet or any wireless communication device. The Contractor shall protect from inappropriate use or disclosure any password, user ID, or other mechanism or code permitting access to any database containing PI, and shall give EOHHS prior notice of any change in personnel whenever the change requires a termination or modification of any password, user ID, or other security mechanism or code that EOHHS may give to the Contractor for access to EOHHS databases to maintain the integrity of the database.

The Contractor agrees to allow representatives of EOHHS access to its premises where PI is kept for the purpose of inspecting privacy and physical security arrangements implemented by the Contractor to protect such data.
Upon request, the Contractor shall provide EOHHS with copies of all written policies, procedure, standards and guidelines related to the protection, security, use and disclosure of PI, Commonwealth Security Information, or other confidential information and the security and integrity of its technology resources.

Commonwealth Security Information

If through this Contract the Contractor obtains access to any Commonwealth Security Information, the Contractor is prohibited from making any disclosures of or about such information, unless in accord with EOHHS's express written instructions. If the Contractor is granted access to such information in order to perform its obligations under this Contract, the Contractor may only use such information for the purposes for which it obtained access. In using the information for such permitted purposes, the Contractor shall limit access to the information only to staff or agents necessary to perform the permitted purposes. While in possession of such information, the Contractor shall apply all privacy and security requirements set forth in this Contract, as applicable to maintain the confidentiality, security, integrity, and availability of such information. Notwithstanding any other provision in this Contract, the Contractor shall report any non-permitted use or disclosure of such information to EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) immediately within twenty-four hours. the Contractor shall immediately take

all reasonable and legal actions to retrieve such information if disclosed to any non-permitted individual or entity; shall include a summary of such retrieval actions in its required report of the non-permitted disclosure; and shall take such further retrieval action as EOHHS shall require. Notwithstanding any other provision in this Contract regarding termination the Contractor may not retain any Commonwealth Security Information upon termination of this Contract, unless such information is expressly identified in any retention permission granted in accordance with subsection **F** (Effect of Termination). If retention is expressly permitted, all data protections stated herein survive termination of this Contract and shall apply for as long as the Contractor retains the information.

Non-Permitted Use or Disclosure Report and Mitigation Activities

As used in this subsection, the term Event refers to the following, either individually or collectively: 1) any use or disclosure of PI by the Contractor, its subcontractors or agents, not permitted under this Contract, 2) any Security Incident by the same, or 3) any event that would trigger consumer or oversight agency notification obligations under the Privacy Rule, Mass. Gen. Laws 93H, or other similar federal or state data privacy or security laws.

Immediately upon becoming aware of an Event, the Contractor shall take all appropriate lawful action necessary to: (1) retrieve, to the extent practicable, any PI involved in the Event; (2) mitigate, to the extent practicable, any known harmful effect of the Event; and (3) take such further action as may be required by any applicable state or federal law concerning the privacy and security of any PI involved in the Event. As soon as possible, but in any event no later than two business days following the date upon which the Contractor becomes aware of the Event, the Contractor shall verbally report the Event to EOHHS with as much of the details listed below as possible, and shall follow such verbal report within five business days with a written report outlining the Event with the following details:

a. The date of the Event, if known or if not known, the estimated date;

b. The date of the discovery of the Event;

c. The nature of the Event, including as much specific detail as possible describing the Event (for example, cause, contributing factors, chronology of events) and the nature of the PI involved (for example, types of identifiers involved such as name, address, age, social security numbers or account numbers, or medical or financial or other types of information). Include any sample forms or documents that were involved in the Event to illustrate the type of PI involved (with personal identifiers removed or redacted), and include any policies and procedures, standards, guidelines, and staff training relevant to the event or to the types of PI involved in the Event;

d. The exact number of individuals whose PI was involved in the Event, if known, or if not known, a reasonable estimate based on the known facts, together with a description of how the exact or estimated number of individuals was determined (If

different types of PI was involved for different individuals, please categorize the exact or estimated numbers of individuals involved according to type of PI);

e. A summary of the nature and scope of the Contractor investigation of the Event;

f. The harmful effects of the Event known to the Contractor, all actions the Contractor has taken or plans to take to mitigate such effects, and the results of all mitigating actions already taken; and

g. A review of and any plans to implement changes to the Contractor's policies and procedures, including staff training, to prevent such Event in the future. Include copies of all written policies and procedures reviewed, developed or amended in connection with the Event.

If within the timeframes specified, the Contractor is unable to gather and confirm all details surrounding the Event, the Contractor shall explain the factors delaying its investigation, provide as much detail as possible, and outline actions it intends to take to further gather and confirm facts surrounding the Event. Upon EOHHS's request the Contractor shall take such further actions as directed by EOHHS to provide further information and clarify any issues or questions that EOHHS may have regarding the Event.

Upon EOHHS's request, the Contractor shall take such further actions as identified by EOHHS or shall take such additional action to assist EOHHS to further mitigate, to the extent practicable, any harmful effect of the Event. Any actions to mitigate harmful effects of such privacy or security violations undertaken by the Contractor on its own initiative or pursuant to EOHHS's request under this paragraph shall not relieve the Contractor of its obligations to report such violations under this paragraph or any other provisions of this Agreement.

Consumer Notification

In the event the consumer notification provisions of Mass. Gen. Laws c. 93H or similar notification requirements in other state or federal laws, are triggered by a data breach involving the Contractor, its employees, agents, or subcontractors, the Contractor shall promptly comply with its obligations under such laws. If EOHHS determines, in its sole discretion, that it is required to give such notifications, the Contractor shall, at EOHHS' request, assist EOHHS in undertaking all actions necessary to meet consumer notification requirements and in drafting the consumer notices and any related required notices to state or federal agencies for EOHHS review and approval, but in no event shall the Contractor have the authority to give these notifications on EOHHS behalf. The Contractor shall reimburse EOHHS for reasonable costs incurred by EOHHS associated with such notification, but only to the extent that such costs are due to: (i) the Contractor's failure to meet its responsibilities under, or in violation of, any provision of this Contract, (ii) the Contractor's violation of law, (iii) the Contractor's negligence, (iv) the Contractor's failure to protect data under its control with encryption or other security

measures that constitute an explicit safe-harbor or exception to any requirement to give notice under such laws, or (v) any activity or omission of its employees, agents, or subcontractors resulting in or contributing to a breach triggering such laws.

Response to Legal Process

The Contractor shall report to the EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office), both verbally and in writing, any instance where PI, Commonwealth Security Information, or any other data obtained under this Contract is subpoenaed or becomes the subject of a court or administrative order or other legal process. If EOHHS directs the Contractor to respond, the Contractor shall take all necessary legal steps, including objecting to the request when appropriate, to comply with Mass. Gen. Laws c. 66A, 42 CFR 431.306 (f), and any other applicable federal and state law. If EOHHS determines that it shall respond directly, the Contractor shall fully cooperate and assist EOHHS in its response. In no event shall the Contractor's reporting obligations under this paragraph be delayed beyond two business days preceding the return date in the subpoena or legal process, or two business days from obtaining such request for data, whichever is shorter.

Individual's Request for Access to PI

The Contractor shall take such action as may be requested by EOHHS for any EOHHS-CE to meet obligations under 45 CFR §§ 164.524, 164.526, and 164.528 with respect to any such EOHHS-CE's PI in Contractor 's possession in sufficient time and manner for EOHHS or the EOHHS-CE to meet its obligations under such Privacy Rule provisions. If an Individual contacts the Contractor with respect to exercising any rights the Individual may have under 45 CFR §§ 164.524, 164.526, and 164.528 with respect to PI in the Contractor's possession, the Contractor shall notify EOHHS within two business days of the Individual's request and cooperate with EOHHS or the applicable EOHHS-CE to meet any EOHHS-CE's obligations with respect to such request.

With respect to an Individual's right to an accounting under 45 CFR § 164.528, the Contractor shall document all disclosures of PI and other data access activities as would be necessary for EOHHS to respond to a request by an Individual for an accounting in accord with 45 CFR § 164.528. Within ten business days of the execution of the 4th Amendment to this Contract, the Contractor shall provide EOHHS with a written description of its tracking system to meet accounting obligations under 45 CFR § 164.528.

Individual's Direct Authorization to Disclose PI to Third Party

In the event the Contractor receives a request from the Individual or from a third party to release PI to a third party pursuant to a consent, authorization, or other written document, the Contractor shall, within three business days of receipt of such consent, authorization, or other written document, notify EOHHS Privacy Office of receipt of the document, shall cooperate with the Privacy Office in confirming the validity and sufficiency of such

document before releasing any PI to the third party, and shall release PI only in accordance with the Privacy Office's instructions.

If an Individual or a third party directly submits to the Contractor a consent, authorization or other written document to disclose PI to a specified third party, the Contractor shall disclose the specified PI to the specified third person only after confirming that the written consent, authorization, or document complies with all requirements under the Privacy Rule, and any other applicable state or federal law. the Contractor may release PI upon receipt of a EOHHS Permission to Share form, provided required elements of the form are completed and the form is signed by the Individual, and no other additional information is required to be included on the form under other applicable state or federal law. If additional information is required under other applicable state or federal law, the data may not be released unless the Contractor obtains a compliant release under such law. If the authorization involves PI not in its possession, the Contractor shall, within three business days of receipt of such authorization, notify EOHHS of the authorization in writing and provide a copy of any written authorization.

Individual's Request for PI Amendment

Within five business days of receipt of EOHHS's written request, the Contractor shall make any amendment(s) to PI that EOHHS requests in order for EOHHS to meet its obligations under 45 CFR § 164.526. Such amendments shall be made in a manner specified in, and in accord with any time requirement under, 45 CFR § 164.526. the Contractor shall notify EOHHS in writing of any request under 54 CFR § 164.526 for an amendment to PI maintained under this Contract that an Individual makes directly to the Contractor, within three days of receiving such request, and shall proceed in accord with EOHHS's instructions.

Accountable Disclosures

The Contractor shall document all disclosures of PI, and required information related to such disclosures, as would be necessary for EOHHS to respond to a request by an Individual for an accounting of disclosures of PI and related information in accord with 45 CFR § 164.528. Within five business days of EOHHS's written request, the Contractor shall make a listing of such disclosures and related information available to EOHHS, or upon EOHHS's direction to the Individual. In the event an Individual makes a request for an accounting, under 45 CFR § 164.528, directly to the Contractor, the Contractor shall, within three business days of receipt of such request, notify EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) of the request, and cooperate in responding to such request with respect to PI maintained under this Contract. Within ten business days of the execution of this Contract, the Contractor shall provide EOHHS Privacy Office with a written description of its tracking system for accountable disclosures. The Contractor shall work with EOHHS Privacy Office in developing a process whereby the Contractor reports accountable disclosures to EOHHS on a routine basis.

Compliance Access for Secretary

The Contractor shall make its internal practices, books, and records, including policies and procedures and PI, relating to the use and disclosure of PI received from, or created or received by it on behalf of, EOHHS, available to EOHHS or upon EOHHS's written request, to the Secretary, in a time and manner designated by either EOHHS or the Secretary for purposes of the Secretary determining EOHHS's compliance with the Privacy and Security Rules.

Under the modifications to the Privacy and Security Rules referenced in this **Section 14**, the Contractor must comply with any direct obligation that it may have under such modifications to comply with any request from the Secretary.

Electronic and Paper Databases Updates

Within 30 days of execution of this Contract, the Contractor shall provide EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office), an accurate list of electronic and paper databases containing PI, together with a description of the various uses of the databases. The Contractor shall update such lists as necessary in accord with the addition or termination of such databases.

Data Privacy and Security Custodian

Within five days of this Contract's effective date, the Contractor shall provide EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) in writing with the name of an individual(s), who shall act as the Contractor's Privacy and Security Officer(s) and be responsible for compliance with this **Section 14**. The Contractor shall also notify EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) in writing within five business days of any transfer of such duties to other persons within its organization.

Permitted Uses and Disclosures by the Contractor

Except as otherwise limited in this Contract, the Contractor may use or disclose PI only as follows:

Contract Functions and Services

Except as otherwise limited in this Contract, the Contractor may use or disclose PI to perform functions, activities, or services for, or on behalf of, EOHHS as specified in this Contract, amendments thereto, or any written work plan or instructions during the course of the Contract, provided such use or disclosure would not: (1) violate the Privacy Rule or other applicable laws such as 42 CFR Subpart F and Mass. Gen. Laws c. 66A if done by EOHHS; (2) violate the minimum necessary policies and procedures of EOHHS; or (3) conflict with statements in EOHHS's Notice of Privacy Practices. In performing functions, activities, or services under this Contract, the Contractor represents that it shall seek from EOHHS only the amount of PI that is minimally necessary to perform the particular function, activity, or service. To the extent this Contract permits the Contractor to request, on EOHHS's behalf, PI from other covered entities under the Privacy Rule,

the Contractor shall only request an amount of PI that is reasonably limited to the minimal necessary to perform the intended function, activity, or service.

Required By Law

The Contractor may use or disclose PI as Required by Law, consistent with the restrictions of 42 CFR 431.306 (f), Mass. Gen. Laws c. 66A, and the restrictions in any other applicable privacy or security law (state or federal) governing the Contractor's use, disclosure, and maintenance of any PI under this Contract.

Restriction on Contacting the Individual

The Contractor may not use PI to attempt to contact the Individual, unless such contact is otherwise specified in the Contract as necessary to perform functions, activities, or services for EOHHS under this Contract, or unless EOHHS otherwise instructs the Contractor to do so in writing.

Publication Restriction

The Contractor shall not use PI for any of its own publication, statistical tabulation, research, or similar purpose, even if PI has been transformed into de-identified data in accord with the standards set forth in 45 CFR 164.514(a), (b), and (c)), unless the Contractor obtains EOHHS's prior written permission and complies with any conditions set forth in such permission.

Contractor's Activities as a managed care entity subject to HIPAA

Contractor may use or disclose PI obtained in it role as a business associate for its own activities as a managed care entity in the following circumstances:

its receipt of PI from EOHHS in its role as a covered entity would meet the requirements of 45 CFR 506(c)(4) if EOHHS had made the disclosure of PI to the Contractor as a Covered Entity, and not a business associate;

as agreed to by EOHHS in writing during the course of this Contract; and

for its proper management and administration, provided:

it first determines whether it can reasonably use de-identified data for such management and administrative activities, and if it can, de-identifies PI in accord with standards set forth in the Privacy Rule for such activities;

it only uses PI for management and administrative activities that are directly related to its performance under this Contract;

the use and disclosure of PI for such management and administrative activities is necessary and complies with minimally necessary principles;

one of the following two conditions is met for disclosures:

the disclosure is Required by Law; or

it (a) obtains reasonable assurances from the person to whom the PI is disclosed that the PI will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person; and (b) the person to whom the PI is disclosed notifies Contractor of any instances of which it is aware in which the confidentiality of the PI has been breached.

Nothing set forth in this subsection **C.5** is intended to circumvent any legal or other requirement to obtain the written consent of the individual to whom the PI applies if such consent is required for the transfer of PI to the Contractor in a role other than as EOHHS' business associate, including, for example, the requirements of 45 CFR Part 2 or the requirements and procedures established by EOHHS for use of the electronic CANS system. In such circumstances, Contractor must obtain the required written consent and maintain documentation of such consent.

Notwithstanding any language in this section C. or the "Contract", Contractor may not use or disclose any PI without consent, if such use and disclosure requires written consent under applicable law (including for example 45 CFR Part 2) or any EOHHS policy and procedure (including for example, use of EOHHS CANs electronic exchange system.).

EOHHS Obligations

Changes in Notice of Privacy Practices

EOHHS shall notify the Contractor in writing of any changes in its notice of privacy practices issued in accordance with 45 CFR § 164.520, to the extent that such change may affect the Contractor's use or disclosure of PI. EOHHS shall provide the Contractor with a new copy of its notice of privacy practices each time such notice is modified or amended.

Notification of Changes in Authorizations to Disclose

EOHHS shall notify the Contractor in writing of any changes in, or revocation of, permission by an Individual to use or disclose PI, to the extent that such changes may affect the Contractor's use or disclosure of PI.

Notification of Restrictions

EOHHS shall notify the Contractor in writing of any restriction to the use of disclosure of PI that it has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect the Contractor's use or disclosure of PI.

Termination for Privacy or Security Violation

Termination for Violation

Notwithstanding any other provision in this Contract, EOHHS may terminate this Contract, immediately upon written notice, if EOHHS determines, in its sole discretion, that the Contractor has materially breached any of its obligations set forth in this **Section 14** or any other provision of this Contract pertaining to the security and privacy of any PI provided to the Contractor under this Contract.

Cure

Prior to terminating this Contract as permitted above, EOHHS, in its sole discretion, may provide an opportunity for the Contractor to cure the breach or end the violation. If such an opportunity is provided, but cure is not feasible, or the Contractor fails to cure the breach or end the violation within a time period set by EOHHS, EOHHS may terminate the Contract immediately upon written notice.

HHS Report

In the event that termination of this Contract for a material breach of any obligation regarding PI is not feasible, or if cure is not feasible, EOHHS shall report such breach or violation to the Secretary if such material breach and termination pertains to work performed for an EOHHS-CE, under this Contract.

Effect of Termination

Return or Destroy Data

Except as provided immediately below, upon termination of this Contract for any reason whatsoever, the Contractor shall, at EOHHS's option, either return or destroy all PI obtained or created in any form under this Contract, and the Contractor shall not retain any copies of such data in any form. In no event shall the Contractor destroy any PI without first obtaining EOHHS's approval. In the event destruction is permitted, the Contractor shall destroy PI in accord with standards set forth in NIST Special Publication 800-98, Guidelines for Media Sanitization, all applicable state retention laws, all applicable state and federal security laws (including the HITECH Act), and all state data security policies including policies issued by EOHHS and the Information Technology Division. Within five days of any permitted destruction, the Contractor shall provide EOHHS with a written certification that destruction has been completed in accord with the required standards and that the Contractor and its subcontractors and agents no longer retain such data or copies of such data. This provision shall apply to all PI in the possession of Contractor's subcontractors or agents, and the Contractor shall ensure that all such data in the possession of its subcontractors or agents has been returned or

destroyed and that no subcontractor or agent retains any copies of such data in any form, in accord with EOHHS's instructions

Retain Data

If the Contractor determines that returning or destroying PI is not feasible, the Contractor shall provide EOHHS with written notification of the conditions that make return or destruction not feasible. If based on Contractor's representations, EOHHS concurs that return or destruction is not feasible, the Contractor shall extend all protections set forth in this **Section 14** to all such PI and shall limit further uses and disclosures of such data to those purposes that make the return or destruction of such data not feasible, for as long as the Contractor maintains the data.

Survival

Notwithstanding any other provision concerning the term of this Contract, all protections pertaining to any PI covered by this Contract shall continue to apply until such time as all such data is returned to EOHHS or destroyed, or until any period of storage following the termination of this Contract is ended, or if return or destruction is not feasible, protections are applied to such data in accord with subsection **2**, immediately above.

Miscellaneous Provisions

Regulatory References

Any reference in this Contract to a section in the Privacy or Security Rules or other regulation or law refers to that section as in effect or as amended.

Amendment

The Contractor agrees to take such action as is necessary to amend this Contract in order for EOHHS to comply with any requirements of the Privacy and Security Rules, the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), and any other applicable state or federal law pertaining to the privacy, confidentiality, or security of PI. Upon EOHHS's written request, the Contractor agrees to enter promptly into negotiations for any amendment as EOHHS, in its sole discretion, deems necessary for EOHHS's compliance with any such laws. The Contractor agrees that, notwithstanding any other provision in this Contract, EOHHS may terminate this Contract immediately upon written notice, in the event the Contractor fails to enter into negotiations for, and to execute, any such amendment.

Survival

The obligations of the Contractor under subsection **F** (Effect of Termination) of this **Section 14** or any provision allowing for continued possession of PI shall survive the termination of this Agreement.

Waiver

EOHHS's exercise or non-exercise of any authority under this Contract, or the exercise or non-exercise of inspection or approval of privacy or security practices or approval of subcontractors, shall not relieve the Contractor of any obligations set forth herein, nor be construed as a waiver of any of the Contractor's obligations or as an acceptance of any unsatisfactory practices or privacy or security failures or breaches by the Contractor.

Interpretation

Any ambiguity in this Contract shall be resolved to permit EOHHS to comply with the Privacy and Security Rules, HIPAA, M.G.L c. 66A, M.G.L. c. 93H, and any other relevant state or federal requirement.

Appendix VIII: MBHP Amendment 20 Fully Executed

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

This form is jointly issued and published by the Executive Office for Administration and Finance (ANF), the Office of the Comptroller (CTR) and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. Any changes to the official printed language of this form shall be void. Additional non-conflicting terms may be added by Attachment. Contractors may not require any additional agreements, engagement letters, contract forms or other additional terms as part of this Contract without prior Department approval. Click on hyperlinks for definitions, instructions and legal requirements that are incorporated by reference into this Contract. An electronic copy of this form is available at www.mass.gov/osc under Guidance For Vendors - Forms or www.mass.gov/osd under OSD Forms.

CONTRACTOR LEGAL NAME: Massachusetts Behavioral Health Partnership (and d/b/a):	**COMMONWEALTH DEPARTMENT NAME**: Exec. Off. of Health and Human Services **MMARS Department Code**: EHS
Legal Address: (W-9, W-4,T&C): 1000 Washington St., Ste. 310, Boston, MA 02118-5002	**Business Mailing Address**: One Ashburton Place, 11th Floor, Boston, MA, 02108
Contract Manager: Carol Kress	**Billing Address** (if different): 600 Washington Street, Boston, MA 02111
E-Mail: Carol.kress@valueoptions.com	**Contract Manager**: Emily Sherwood
Phone: 617-790-4144 Fax:	**E-Mail**: Emily.Sherwood@state.ma.us
Contractor Vendor Code: VC6000182737	**Phone**:617-573-1759 Fax:
Vendor Code Address ID (e.g. "AD001"): AD001 (Note: The Address Id Must be set up for EFT payments.)	**MMARS Doc ID(s):** N/A **RFR/Procurement or Other ID Number**:11LCEHSPCCPLANBHPMSSRFR
___ **NEW CONTRACT** **PROCUREMENT OR EXCEPTION TYPE**: (Check one option only) __ Statewide Contract (OSD or an OSD-designated Department) __ Collective Purchase (Attach OSD approval, scope, budget) __ Department Procurement (includes State or Federal grants 815 CMR 2.00) (Attach RFR and Response or other procurement supporting documentation) __ Emergency Contract (Attach justification for emergency, scope, budget) __ Contract Employee (Attach Employment Status Form, scope, budget) __ Legislative/Legal or Other: (Attach authorizing language/justification, scope and budget)	_X_ **CONTRACT AMENDMENT** Enter **Current Contract End Date** ***Prior*** to Amendment: 6/30/2017 , Enter **Amendment Amount**: $ No Change. (or "no change") **AMENDMENT TYPE**: (Check one option only. Attach details of Amendment changes.) x Amendment to Scope or Budget (Attach updated scope and budget) __ Interim Contract (Attach justification for Interim Contract and updated scope/budget) __ Contract Employee (Attach any updates to scope or budget) __ Legislative/Legal or Other: (Attach authorizing language/justification and updated scope and budget)

The following COMMONWEALTH TERMS AND CONDITIONS (T&C) has been executed, filed with CTR and is incorporated by reference into this Contract.

_x_ Commonwealth Terms and Conditions __ Commonwealth Terms and Conditions For Human and Social Services

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.

x Rate Contract (No Maximum Obligation. Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)

__ Maximum Obligation Contract Enter Total Maximum Obligation for total duration of this Contract (or ***new*** Total if Contract is being amended). $ _____.

PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within 10 days __% PPD; Payment issued within 15 days __ % PPD; Payment issued within 20 days __ % PPD; Payment issued within 30 days __% PPD. If PPD percentages are left blank, identify reason: __agree to standard 45 day cycle __ statutory/legal or Ready Payments (G.L. c. 29, § 23A); __ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attached all supporting documentation and justifications.) **Amendment #20** to the Contract is for the purpose of deleting and replacing the table of ESP Core Staffing Positions in Section 3.1.B.20(c)(iii); adjusting Base Capitation Rates to Account for the Health Insurer Provider Fee (HIPF) for CY2014; and deleting and replacing Appendix H-1: Payment and Risk Sharing Provisions.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

_x_ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.

__ 2. may be incurred as of _____, **20**___, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.

__3. were incurred as of _____, **20**___ , a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of 6/30/2017, with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor makes all certifications required under the attached Contractor Certifications (incorporated by reference if not attached hereto) under the pains and penalties of perjury, agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form including the Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR: X: _____, Date: _____, (Signature and Date Must Be Handwritten At Time of Signature) **Print Name:** Carol Kress **Print Title:** Vice President, Client Partnerships, MBHP	**AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:** X: _____, Date: 10/30/15, (Signature and Date Must Be Handwritten At Time of Signature) **Print Name:** Daniel Tsai **Print Title:** Assistant Secretary for MassHealth

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

INSTRUCTIONS AND CONTRACTOR CERTIFICATIONS

The following instructions and terms are incorporated by reference and apply to this Standard Contract Form. Text that appears underlined indicates a "hyperlink" to an Internet or bookmarked site and are unofficial versions of these documents and Departments and Contractors should consult with their legal counsel to ensure compliance with all legal requirements. Using the Web Toolbar will make navigation between the form and the hyperlinks easier. Please note that not all applicable laws have been cited.

CONTRACTOR LEGAL NAME (AND D/B/A): Enter the **Full Legal Name** of the Contractor's business as it appears on the Contractor's W-9 or W-4 Form (Contract Employees only) **and** the applicable Commonwealth Terms and Conditions If Contractor also has a "doing business as" (d/b/a) name, BOTH the legal name and the "d/b/a" name must appear in this section.

Contractor Legal Address: Enter the Legal Address of the Contractor as it appears on the Contractor's W-9 or W-4 Form (Contract Employees only) **and** the applicable Commonwealth Terms and Conditions, which must match the legal address on the 1099I table in MMARS (or the Legal Address in HR/CMS for Contract Employee).

Contractor Contract Manager: Enter the authorized Contract Manager who will be responsible for managing the Contract. The Contract Manager should be an Authorized Signatory or, at a minimum, a person designated by the Contractor to represent the Contractor, receive legal notices and negotiate ongoing Contract issues. The Contract Manager is considered "Key Personnel" and may not be changed without the prior written approval of the Department. If the Contract is posted on COMMBUYS, the name of the Contract Manager must be included in the Contract on COMMBUYS.

Contractor E-Mail Address/Phone/Fax: Enter the electronic mail (e-mail) address, phone and fax number of the Contractor Contract Manager. This information must be kept current by the Contractor to ensure that the Department can contact the Contractor and provide any required legal notices. Notice received by the Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address will meet any written legal notice requirements.

Contractor Vendor Code: The Department must enter the MMARS **Vendor Code** assigned by the Commonwealth. If a Vendor Code has not yet been assigned, leave this space blank and the Department will complete this section when a Vendor Code has been assigned. The Department is responsible under the Vendor File and W-9s Policy for verifying with authorized signatories of the Contractor, as part of contract execution, that the legal name, address and Federal Tax Identification Number (TIN) in the Contract documents match the state accounting system.

Vendor Code Address ID: (e.g., "AD001") The Department must enter the MMARS Vendor Code Address Id identifying the payment remittance address for Contract payments, which MUST be set up for EFT payments PRIOR to the first payment under the Contract in accordance with the Bill Paying and Vendor File and W-9 policies.

COMMONWEALTH DEPARTMENT NAME: Enter the full Department name with the authority to obligate funds encumbered for the Contract.

Commonwealth MMARS Alpha Department Code: Enter the three (3) letter MMARS Code assigned to this Commonwealth Department in the state accounting system.

Department Business Mailing Address: Enter the address where all formal correspondence to the Department must be sent. Unless otherwise specified in the Contract, legal notice sent or received by the Department's Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address for the Contract Manager will meet any requirements for legal notice.

Department Billing Address: Enter the Billing Address or email address if invoices must be sent to a different location. Billing or confirmation of delivery of performance issues should be resolved through the listed Contract Managers.

Department Contract Manager: Identify the authorized Contract Manager who will be responsible for managing the Contract, who should be an authorized signatory or an employee designated by the Department to represent the Department to receive legal notices and negotiate ongoing Contract issues.

Department E-Mail Address/Phone/Fax: Enter the electronic mail (e-mail) address, phone and fax number of the Department Contract Manager. Unless otherwise specified in the Contract, legal notice sent or received by the Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address will meet any requirements for written notice under the Contract.

MMARS Document ID(s): Enter the MMARS 20 character encumbrance transaction number associated with this Contract which must remain the same for the life of the Contract. If multiple numbers exist for this Contract, identify all Doc Ids.

RFR/Procurement or Other ID Number or Name: Enter the Request for Response (RFR) or other Procurement Reference number, Contract ID Number or other reference/tracking number for this Contract or Amendment and will be entered into the Board Award Field in the MMARS encumbrance transaction for this Contract.

NEW CONTRACTS (left side of Form):

Complete this section ONLY if this Contract is brand new. (Complete the CONTRACT AMENDMENT section for any material changes to an existing or an expired Contract, and for exercising options to renew or annual contracts under a multi-year procurement or grant program.)

PROCUREMENT OR EXCEPTION TYPE: Check the appropriate type of procurement or exception for this Contract. Only one option can be selected. See State Finance Law and General Requirements, Acquisition Policy and Fixed Assets, the Commodities and Services Policy and the Procurement Information Center (Department Contract Guidance) for details.

Statewide Contract (OSD or an OSD-designated Department). Check this option for a Statewide Contract under OSD, or by an OSD-designated Department.

Collective Purchase approved by OSD. Check this option for Contracts approved by OSD for collective purchases through federal, state, local government or other entities.

Department Contract Procurement. Check this option for a Department procurement including state grants and federal sub-grants under 815 CMR 2.00 and State Grants and Federal Subgrants Policy, Departmental Master Agreements (MA). If multi-Department user Contract, identify multi-Department use is allowable in Brief Description.

Emergency Contract. Check this option when the Department has determined that an unforeseen crisis or incident has arisen which requires or mandates immediate purchases to avoid substantial harm to the functioning of government or the provision of necessary or mandated services or whenever the health, welfare or safety of clients or other persons or serious damage to property is threatened.

Contract Employee. Check this option when the Department requires the performance of an Individual Contractor, and when the planned Contract performance with an Individual has been classified using the Employment Status Form (prior to the Contractor's selection) as work of a Contract Employee and not that of an Independent Contractor.

Legislative/Legal or Other. Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Supporting documentation must be attached to explain and justify the exemption.

CONTRACT AMENDMENT (Right Side of Form)

Complete this section for any Contract being renewed, amended or to continue a lapsed Contract. All Contracts with available options to renew must be amended referencing the original procurement and Contract doc ids, since all continuing contracts must be maintained in the same Contract file (even if the underlying appropriation changes each fiscal year.) "See Amendments, Suspensions, and Termination Policy.)

Enter Current Contract End Date: Enter the termination date of the Current Contract being amended, even if this date has already passed. (Note: Current Start Date is not requested since this date does not change and is already recorded in MMARS.)

Enter Amendment Amount: Enter the amount of the Amendment increase or decrease to a Maximum Obligation Contract. Enter "no change" for Rate Contracts or if no change.

AMENDMENT TYPE: Identify the type of Amendment being done. Documentation supporting the updates to performance and budget must be attached. **Amendment to Scope or Budget.** Check this option when renewing a Contract or executing any Amendment ("material change" in Contract terms) even if the Contract has lapsed. The parties may negotiate a change in any element of Contract performance or cost identified in the RFR or the Contractor's response which results in lower costs, or a more cost-effective or better value performance than was presented in the original selected response, provided the negotiation results in a better value within the scope of the RFR than what was proposed by the Contractor in the original selected response. Any "material" change in the Contract terms must be memorialized in a formal Amendment even if a corresponding MMARS transaction is not needed to support the change. Additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

Interim Contracts. Check this option for an Interim Contract to prevent a lapse of Contract performance whenever an existing Contract is being re-procured but the new procurement has not been completed, to bridge the gap during implementation between an expiring and a new procurement, or to contract with an interim Contractor when a current Contractor is unable to complete full performance under a Contract.

Contract Employee. Check this option when the Department requires a renewal or other amendment to the performance of a Contract Employee.

Legislative/Legal or Other. Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Attach supporting documentation to explain and justify the exemption and whether Contractor selection has been publicly posted.

COMMONWEALTH TERMS AND CONDITIONS

Identify which Commonwealth Terms and Conditions the Contractor has executed and is incorporated by reference into this Contract. This Form is signed only once and recorded on the Vendor Customer File (VCUST). See Vendor File and W-9s Policy.

COMPENSATION

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

Identify if the Contract is a **Rate Contract** (with no stated Maximum Obligation) or a **Maximum Obligation Contract** (with a stated Maximum Obligation) and identify the Maximum Obligation. If the Contract is being amended, enter the new Maximum Obligation based upon the increase or decreasing Amendment. The Total Maximum Obligation must reflect the total funding for the dates of service under the contract, including the Amendment amount if the Contract is being amended. The Maximum Obligation must match the MMARS encumbrance. Funding and allotments must be verified as available and encumbered prior to incurring obligations. If a Contract includes both a Maximum Obligation component and Rate Contract component, check off both, specific Maximum Obligation amounts or amended amounts and Attachments must clearly outline the Contract breakdown to match the encumbrance.

PAYMENTS AND PROMPT PAY DISCOUNTS

Payments are processed within a 45 day payment cycle through EFT in accordance with the Commonwealth Bill Paying Policy for investment and cash flow purposes. Departments may NOT negotiate accelerated payments and Payees are NOT entitled to accelerated payments UNLESS a prompt payment discount (PPD) is provided to support the Commonwealth's loss of investment earnings for this earlier payment, or unless a payments is legally mandated to be made in less than 45 days (e.g., construction contracts, Ready Payments under G.L. c. 29, s. 23A). See Prompt Pay Discounts Policy. PPD are identified as a percentage discount which will be automatically deducted when an accelerated payment is made. Reduced contracts rates may not be negotiated to replace a PPD. If PPD fields are left blank please identify that the Contractor agrees to the standard 45 day cycle; a statutory/legal exemption such as Ready Payments (G.L. c. 29, § 23A); or only an initial accelerated payment for reimbursements or start up costs for a grant, with subsequent payments scheduled to support standard EFT 45 day payment cycle. Financial hardship is not a sufficient justification to accelerate cash flow for *all* payments under a Contract. Initial grant or contract payments may be accelerated for the *first* invoice or initial grant installment, but subsequent periodic installments or invoice payments should be scheduled to support the Payee cash flow needs and the standard 45 day EFT payment cycle in accordance with the Bill Paying Policy. Any accelerated payment that does not provide for a PPD must have a legal justification in Contract file for audit purposes explaining why accelerated payments were allowable without a PPD.

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE

Enter a brief description of the Contract performance, project name and/or other identifying information for the Contract to specifically identify the Contract performance, match the Contract with attachments, determine the appropriate expenditure code (as listed in the Expenditure Classification Handbook) or to identify or clarify important information related to the Contract such as the Fiscal Year(s) of performance (ex. "FY2012" or "FY2012-14"). Identify settlements or other exceptions and attach more detailed justification and supporting documents. Enter "Multi-Department Use" if other Departments can access procurement. For Amendments, identify the purpose and what items are being amended. Merely stating "see attached" or referencing attachments without a narrative description of performance is insufficient.

ANTICIPATED START DATE

The Department and Contractor must certify WHEN obligations under this Contract/Amendment may be incurred. Option 1 is the default option when performance may begin as of the Effective Date (latest signature date and any required approvals). If the parties want a new Contract or renewal to begin as of the upcoming fiscal year then list the fiscal year(s) (ex. "FY2012" or "FY2012-14") in the Brief Description section. Performance starts and encumbrances reflect the default Effective Date (if no FY is listed) or the later FY start date (if a FY is listed). Use Option 2 only when the Contract will be signed well in advance of the start date and identify a specific future start date. Do not use Option 2 for a fiscal year start unless it is certain that the Contract will be signed prior to fiscal year. Option 3 is used in lieu of the Settlement and Release Form when the Contract/Amendment is signed late, and obligations have already been incurred by the Contractor prior to the Effective Date for which the Department has either requested, accepted or deemed legally eligible for reimbursement, and the Contract includes supporting documents justifying the performance or proof of eligibility, and approximate costs. Any obligations incurred outside the scope of the Effective Date under any Option listed, even if the incorrect Option is selected, shall be automatically deemed a settlement included under the terms of the Contract and upon payment to the Contractor will release the Commonwealth from further obligations for the identified performance. All settlement payments require justification and must be under same encumbrance and object codes as the Contract payments. Performance dates are subject to G.L. c.4, § 9.

CONTRACT END DATE

The Department must enter the date that Contract performance will terminate. **If the Contract is being amended and the Contract End Date is not changing, this date must be re-entered again here.** A Contract must be signed for at least the initial duration but not longer than the period of procurement listed in the RFR, or other solicitation document (if applicable). No new performance is allowable beyond the end date without an amendment, but the Department may allow a Contractor to complete minimal close out performance obligations if substantial performance has been made prior to the termination date of the Contract and prior to the end of the fiscal year in which payments are appropriated, provided that any close out performance is subject to appropriation and funding limits under state finance law, and CTR may adjust encumbrances and payments in the state accounting system to enable final close out payments. Performance dates are subject to G.L. c.4, § 9.

CERTIFICATIONS AND EXECUTION

See Department Head Signature Authorization Policy and the Contractor Authorized Signatory Listing for policies on Contractor and Department signatures.

Authorizing Signature for Contractor/Date: The Authorized Contractor Signatory must (in their own handwriting and in ink) sign AND enter the date the Contract is signed. See section above under "Anticipated Contract Start Date". Acceptance of payment by the Contractor shall waive any right of the Contractor to claim the Contract/Amendment is not valid and the Contractor may not void the Contract. **Rubber stamps, typed or other images are not acceptable**. Proof of Contractor signature authorization on a **Contractor Authorized Signatory Listing** may be required by the Department if not already on file.

Contractor Name /Title: The Contractor Authorized Signatory's name and title must appear legibly as it appears on the **Contractor Authorized Signatory Listing**.

Authorizing Signature For Commonwealth/Date: The Authorized Department Signatory must (in their own handwriting and in ink) sign AND enter the date the Contract is signed. See section above under "Anticipated Start Date". **Rubber stamps, typed or other images are not accepted.** The Authorized Signatory must be an employee within the Department legally responsible for the Contract. See Department Head Signature Authorization. The Department must have the legislative funding appropriated for all the costs of this Contract or funding allocated under an approved Interdepartmental Service Agreement (ISA). A Department may not contract for performance to be delivered to or by another state department without specific legislative authorization (unless this Contract is a Statewide Contract). For Contracts requiring Secretariat signoff, evidence of Secretariat signoff must be included in the Contract file.

Department Name /Title: Enter the Authorized Signatory's name and title legibly.

CONTRACTOR CERTIFICATIONS AND LEGAL REFERENCES

Notwithstanding verbal or other representations by the parties, the "Effective Date" of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified, subject to any required approvals. The Contractor makes all certifications required under this Contract under the pains and penalties of perjury, and agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein:

Commonwealth and Contractor Ownership Rights. The Contractor certifies and agrees that the Commonwealth is entitled to ownership and possession of all "deliverables" purchased or developed with Contract funds. A Department may not relinquish Commonwealth rights to deliverables nor may Contractors sell products developed with Commonwealth resources without just compensation. The Contract should detail all Commonwealth deliverables and ownership rights and any Contractor proprietary rights.

Qualifications. The Contractor certifies it is qualified and shall at all times remain qualified to perform this Contract; that performance shall be timely and meet or exceed industry standards for the performance required, including obtaining requisite licenses, registrations, permits, resources for performance, and sufficient professional, liability; and other appropriate insurance to cover the performance. If the Contractor is a business, the Contractor certifies that it is listed under the Secretary of State's website as licensed to do business in Massachusetts, as required by law.

Business Ethics and Fraud, Waste and Abuse Prevention. The Contractor certifies that performance under this Contract, in addition to meeting the terms of the Contract, will be made using ethical business standards and good stewardship of taxpayer and other public funding and resources to prevent fraud, waste and abuse.

Collusion. The Contractor certifies that this Contract has been offered in good faith and without collusion, fraud or unfair trade practices with any other person, that any actions to avoid or frustrate fair and open competition are prohibited by law, and shall be grounds for rejection or disqualification of a Response or termination of this Contract.

Public Records and Access The Contractor shall provide full access to records related to performance and compliance to the Department and officials listed under Executive Order 195 and G.L. c. 11, s.12 seven (7) years beginning on the first day after the final payment under this Contract or such longer period necessary for the resolution of any litigation, claim, negotiation, audit or other inquiry involving this Contract. Access to view Contractor records related to any breach or allegation of fraud, waste and/or abuse may not be denied and Contractor can not claim confidentiality or trade secret protections solely for viewing but not retaining documents. Routine Contract performance compliance reports or documents related to any alleged breach or allegation of non-compliance, fraud, waste, abuse or collusion may be provided electronically and shall be provided at Contractor's own expense. Reasonable costs for copies of non-routine Contract related records shall not exceed the rates for public records under 950 C.M.R. 32.00.

Debarment. The Contractor certifies that neither it nor any of its subcontractors are currently debarred or suspended by the federal or state government under any law or

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regulation including, Executive Order 147; G.L. c. 29, s. 29F G.L. c.30, § 39R, G.L. c.149, § 27C, G.L. c.149, § 44C, G.L. c.149, § 148B and G.L. c. 152, s. 25C.

Applicable Laws. The Contractor shall comply with all applicable state laws and regulations including but not limited to the applicable Massachusetts General Laws; the Official Code of Massachusetts Regulations; Code of Massachusetts Regulations (unofficial); 801 CMR 21.00 (Procurement of Commodity and Service Procurements, Including Human and Social Services); 815 CMR 2.00 (Grants and Subsidies); 808 CMR 1.00 (Compliance, Reporting and Auditing for Human And Social Services); AICPA Standards; confidentiality of Department records under G.L. c. 66A; and the Massachusetts Constitution Article XVIII if applicable.

Invoices. The Contractor must submit invoices in accordance with the terms of the Contract and the Commonwealth Bill Paying Policy. Contractors must be able to reconcile and properly attribute concurrent payments from multiple Departments. Final invoices in any fiscal year must be submitted no later than August 15th for performance made and received (goods delivered, services completed) prior to June 30th, in order to make payment for that performance prior to the close of the fiscal year to prevent reversion of appropriated funds. Failure to submit timely invoices by August 15th or other date listed in the Contract shall authorize the Department to issue an estimated payment based upon the Department's determination of performance delivered and accepted. The Contractor's acceptance of this estimated payment releases the Commonwealth from further claims for these invoices. If budgetary funds revert due to the Contractor's failure to submit timely final invoices, or for disputing an estimated payment, the Department may deduct a penalty up to 10% from any final payment in the next fiscal year for failure to submit timely invoices.

Payments Subject To Appropriation. Pursuant to G.L. c. 29 § 26, § 27 and § 29, Departments are required to expend funds only for the purposes set forth by the Legislature and within the funding limits established through appropriation, allotment and subsidiary, including mandated allotment reductions triggered by G.L. c. 29, § 9C. A Department cannot authorize or accept performance in excess of an existing appropriation and allotment, or sufficient non-appropriated available funds. Any oral or written representations, commitments, or assurances made by the Department or any other Commonwealth representative are not binding. The Commonwealth has no legal obligation to compensate a Contractor for performance that is not requested and is intentionally delivered by a Contractor outside the scope of a Contract. Contractors should verify funding prior to beginning performance.

Intercept. Contractors may be registered as Customers in the Vendor file if the Contractor owes a Commonwealth debt. Unresolved and undisputed debts, and overpayments of Contract payments that are not reimbursed timely shall be subject to intercept pursuant to G.L. c. 7A, s. 3 and 815 CMR 9.00. Contract overpayments will be subject to immediate intercept or payment offset. The Contractor may not penalize any state Department or assess late fees, cancel a Contract or other services if amounts are intercepted or offset due to recoupment of an overpayment, outstanding taxes, child support, other overdue debts or Contract overpayments.

Tax Law Compliance. The Contractor certifies under the pains and penalties of perjury tax compliance with Federal tax laws; state tax laws including but not limited to G.L. c. 62C, G.L. c. 62C, s. 49A; compliance with all state tax laws, reporting of employees and contractors, withholding and remitting of tax withholdings and child support and is in good standing with respect to all state taxes and returns due; reporting of employees and contractors under G.L. c. 62E, withholding and remitting child support including G.L. c. 119A, s. 12; TIR 05-11: New Independent Contractor Provisions and applicable TIRs.

Bankruptcy, Judgments, Potential Structural Changes, Pending Legal Matters and Conflicts. The Contractor certifies it has not been in bankruptcy and/or receivership within the last three calendar years, and the Contractor certifies that it will immediately notify the Department in writing **at least 45 days prior** to filing for bankruptcy and/or receivership, any potential structural change in its organization, or if there is **any risk** to the solvency of the Contractor that may impact the Contractor's ability to timely fulfill the terms of this Contract or Amendment. The Contractor certifies that at any time during the period of the Contract the Contractor is required to affirmatively disclose in writing to the Department Contract Manager the details of any judgment, criminal conviction, investigation or litigation pending against the Contractor or any of its officers, directors, employees, agents, or subcontractors, including any potential conflicts of interest of which the Contractor has knowledge, or learns of during the Contract term. Law firms or Attorneys providing legal services are required to identify any potential conflict with representation of any Department client in accordance with Massachusetts Board of Bar Overseers (BBO) rules.

Federal Anti-Lobbying and Other Federal Requirements. If receiving federal funds, the Contractor certifies compliance with federal anti-lobbying requirements including 31 USC 1352; other federal requirements; Executive Order 11246; Air Pollution Act; Federal Water Pollution Control Act and Federal Employment Laws.

Protection of Personal Data and Information. The Contractor certifies that all steps will be taken to ensure the security and confidentiality of all Commonwealth data for which the Contractor becomes a holder, either as part of performance or inadvertently during performance, with special attention to restricting access, use and disbursement of personal data and information under G.L. c. 93H and c. 66A and Executive Order 504. The Contractor is required to comply with G.L. c. 93I for the proper disposal of all paper and electronic media, backups or systems containing personal data and information, provided further that the Contractor is required to ensure that any personal data or information transmitted electronically or through a portable device be properly encrypted using (at a minimum) Information Technology Division (ITD) Protection of Sensitive Information, provided further that any Contractor having access to credit card or banking information of Commonwealth customers certifies that the Contractor is PCI compliant in accordance with the Payment Card Industry Council Standards and shall provide confirmation compliance during the Contract, provide further that the Contractor shall immediately notify the Department in the event of any security breach including the unauthorized access, disbursement, use or disposal of personal data or information, and in the event of a security breach, the Contractor shall cooperate fully with the Commonwealth and provide access to any information necessary for the Commonwealth to respond to the security breach and shall be fully responsible for any damages associated with the Contractor's breach including but not limited to G.L. c. 214, s. 3B.

Corporate and Business Filings and Reports. The Contractor certifies compliance with any certification, filing, reporting and service of process requirements of the Secretary of the Commonwealth, the Office of the Attorney General or other Departments as related to its conduct of business in the Commonwealth; and with its incorporating state (or foreign entity).

Employer Requirements. Contractors that are employers certify compliance with applicable state and federal employment laws or regulations, including but not limited to G.L. c. 5, s. 1 (Prevailing Wages for Printing and Distribution of Public Documents); G.L. c. 7, s. 22 (Prevailing Wages for Contracts for Meat Products and Clothing and Apparel); minimum wages and prevailing wage programs and payments; unemployment insurance and contributions; workers' compensation and insurance, child labor laws, AGO fair labor practices; G.L. c. 149 (Labor and Industries); G.L. c. 150A (Labor Relations); G.L. c. 151 and 455 CMR 2.00 (Minimum Fair Wages); G.L. c. 151A (Employment and Training); G. L. c. 151B (Unlawful Discrimination); G.L. c. 151E (Business Discrimination); G.L. c. 152 (Workers' Compensation); G.L. c.153 (Liability for Injuries); 29 USC c. 8 (Federal Fair Labor Standards); 29 USC c. 28 and the Federal Family and Medical Leave Act.

Federal And State Laws And Regulations Prohibiting Discrimination including but not limited to the Federal Equal Employment Oppurtunity (EEO) Laws the Americans with Disabilities Act.; 42 U.S.C Sec. 12,101, et seq., the Rehabilitation Act, 29 USC c. 16 s. 794; 29 USC c. 16. s. 701; 29 USC c. 14, 623; the 42 USC c. 45; (Federal Fair Housing Act); G. L. c. 151B (Unlawful Discrimination); G.L. c. 151E (Business Discrimination); the Public Accommodations Law G.L. c. 272, s. 92A; G.L. c. 272, s. 98 and 98A, Massachusetts Constitution Article CXIV and G.L. c. 93, s. 103; 47 USC c. 5, sc. II, Part II, s. 255 (Telecommunication Act; Chapter 149, Section 105D, G.L. c. 151C, G.L. c. 272, Section 92A, Section 98 and Section 98A, and G.L. c. 111, Section 199A, and Massachusetts Disability-Based Non-Discrimination Standards For Executive Branch Entities, and related Standards and Guidance, authorized under Massachusetts Executive Order or any disability-based protection arising from state or federal law or precedent. See also MCAD and MCAD links and Resources.

Small Business Purchasing Program (SBPP). A Contractor may be eligible to participate in the SBPP, created pursuant to Executive Order 523, if qualified through the SBPP COMMBUYS subscription process at: www.commbuys.com and with acceptance of the terms of the SBPP participation agreement.

Limitation of Liability for Information Technology Contracts (and other Contracts as Authorized). The Information Technology Mandatory Specifications and the IT Acquisition Accessibility Contract Language are incorporated by reference into Information Technology Contracts. The following language will apply to Information Technology contracts in the U01, U02, U03, U04, U05, U06, U07, U08, U09, U10, U75, U98 object codes in the Expenditure Classification Handbook or other Contracts as approved by CTR or OSD. Pursuant to Section 11. Indemnification of the Commonwealth Terms and Conditions, the term "other damages" shall include, but shall not be limited to, the reasonable costs the Commonwealth incurs to repair, return, replace or seek cover (purchase of comparable substitute commodities and services) under a Contract. "Other damages" shall not include damages to the Commonwealth as a result of third party claims, provided, however, that the foregoing in no way limits the Commonwealth's right of recovery for personal injury or property damages or patent and copyright infringement under Section 11 nor the Commonwealth's ability to join the contractor as a third party defendant. Further, the term "other damages" shall not include, and in no event shall the contractor be liable for, damages for the Commonwealth's use of contractor provided products or services, loss of Commonwealth records, or data (or other intangible property), loss of use of equipment, lost revenue, lost savings or lost profits of the Commonwealth. In no event shall "other damages" exceed the greater of $100,000, or two times the value of the product or service (as defined in the Contract scope of work) that is the subject of the claim. Section 11 sets forth the contractor's entire liability under a Contract. Nothing in this section shall limit the Commonwealth's ability to negotiate higher limitations of liability in a particular Contract, provided that any such limitation must specifically reference Section 11 of the Commonwealth Terms and Conditions. In the event the limitation of liability conflicts with accounting standards which mandate that there can be no cap of damages, the limitation shall be considered waived for that audit engagement. These terms may be applied to other Contracts only with prior written confirmation from the Operational Services Division or the Office of the Comptroller. The terms in this Clarification may not be modified.

Northern Ireland Certification. Pursuant to G.L. c. 7 s. 22C for state agencies, state authorities, the House of Representatives or the state Senate, by signing this Contract the

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Contractor certifies that it does not employ ten or more employees in an office or other facility in Northern Ireland and if the Contractor employs ten or more employees in an office or other facility located in Northern Ireland the Contractor certifies that it does not discriminate in employment, compensation, or the terms, conditions and privileges of employment on account of religious or political belief; and it promotes religious tolerance within the work place, and the eradication of any manifestations of religious and other illegal discrimination; and the Contractor is not engaged in the manufacture, distribution or sale of firearms, munitions, including rubber or plastic bullets, tear gas, armored vehicles or military aircraft for use or deployment in any activity in Northern Ireland.

Pandemic, Disaster or Emergency Performance. In the event of a serious emergency, pandemic or disaster outside the control of the Department, the Department may negotiate emergency performance from the Contractor to address the immediate needs of the Commonwealth even if not contemplated under the original Contract or procurement. Payments are subject to appropriation and other payment terms.

Consultant Contractor Certifications (For Consultant Contracts "HH" and "NN" and "U05" object codes subject to G.L. Chapter 29, s. 29A). Contractors must make required disclosures as part of the RFR Response or using the Consultant Contractor Mandatory Submission Form.

Attorneys. Attorneys or firms providing legal services or representing Commonwealth Departments may be subject to G.L. c. 30, s. 65, and if providing litigation services must be approved by the Office of the Attorney General to appear on behalf of a Department, and shall have a continuing obligation to notify the Commonwealth of any conflicts of interest arising under the Contract.

Subcontractor Performance. The Contractor certifies full responsibility for Contract performance, including subcontractors, and that comparable Contract terms will be included in subcontracts, and that the Department will not be required to directly or indirectly manage subcontractors or have any payment obligations to subcontractors. .

EXECUTIVE ORDERS

For covered Executive state Departments, the Contractor certifies compliance with applicable Executive Orders (see also Massachusetts Executive Orders), including but not limited to the specific orders listed below. A breach during period of a Contract may be considered a material breach and subject Contractor to appropriate monetary or Contract sanctions.

Executive Order 481. Prohibiting the Use of Undocumented Workers on State Contracts. For all state agencies in the Executive Branch, including all executive offices, boards, commissions, agencies, Departments, divisions, councils, bureaus, and offices, now existing and hereafter established, by signing this Contract the Contractor certifies under the pains and penalties of perjury that they shall not knowingly use undocumented workers in connection with the performance of this Contract; that, pursuant to federal requirements, shall verify the immigration status of workers assigned to a Contract without engaging in unlawful discrimination; and shall not knowingly or recklessly alter, falsify, or accept altered or falsified documents from any such worker

Executive Order 130. Anti-Boycott. The Contractor warrants, represents and agrees that during the time this Contract is in effect, neither it nor any affiliated company, as hereafter defined, participates in or cooperates with an international boycott (See IRC § 999(b)(3)-(4), and IRS Audit Guidelines Boycotts) or engages in conduct declared to be unlawful by G.L. c. 151E, s. 2. A breach in the warranty, representation, and agreement contained in this paragraph, without limiting such other rights as it may have, the Commonwealth shall be entitled to rescind this Contract. As used herein, an affiliated company shall be any business entity of which at least 51% of the ownership interests are directly or indirectly owned by the Contractor or by a person or persons or business entity or entities directly or indirectly owning at least 51% of the ownership interests of the Contractor, or which directly or indirectly owns at least 51% of the ownership interests of the Contractor.

Executive Order 346. Hiring of State Employees By State Contractors Contractor certifies compliance with both the conflict of interest law G.L. c. 268A specifically s. 5 (f) and this order; and includes limitations regarding the hiring of state employees by private companies contracting with the Commonwealth. A privatization contract shall be deemed to include a specific prohibition against the hiring at any time during the term of Contract, and for any position in the Contractor's company, any state management employee who is, was, or will be involved in the preparation of the RFP, the negotiations leading to the awarding of the Contract, the decision to award the Contract, and/or the supervision or oversight of performance under the Contract.

Executive Order 444. Disclosure of Family Relationships With Other State Employees. Each person applying for employment (including Contract work) within the Executive Branch under the Governor must disclose in writing the names of all immediate family related to immediate family by marriage who serve as employees or elected officials of the Commonwealth. All disclosures made by applicants hired by the Executive Branch under the Governor shall be made available for public inspection to the extent permissible by law by the official with whom such disclosure has been filed.

Executive Order 504. Regarding the Security and Confidentiality of Personal Information. For all Contracts involving the Contractor's access to personal information, as defined in G.L. c. 93H, and personal data, as defined in G.L. c. 66A, owned or controlled by Executive Department agencies, or access to agency systems containing such information or data (herein collectively "personal information"), Contractor certifies under the pains and penalties of perjury that the Contractor (1) has read Commonwealth of Massachusetts Executive Order 504 and agrees to protect any and all personal information; and (2) has reviewed all of the Commonwealth **Information Technology Division's Security Policies.** Notwithstanding any contractual provision to the contrary, in connection with the Contractor's performance under this Contract, for all state agencies in the Executive Department, including all executive offices, boards, commissions, agencies, departments, divisions, councils, bureaus, and offices, now existing and hereafter established, the Contractor shall: (1) obtain a copy, review, and comply with the contracting agency's Information Security Program (ISP) and any pertinent security guidelines, standards, and policies; (2) comply with all of the Commonwealth of Massachusetts Information Technology Division's "Security Policies") (3) communicate and enforce the contracting agency's ISP and such Security Policies against all employees (whether such employees are direct or contracted) and subcontractors; (4) implement and maintain any other reasonable appropriate security procedures and practices necessary to protect personal information to which the Contractor is given access by the contracting agency from the unauthorized access, destruction, use, modification, disclosure or loss; (5) be responsible for the full or partial breach of any of these terms by its employees (whether such employees are direct or contracted) or subcontractors during or after the term of this Contract, and any breach of these terms may be regarded as a material breach of this Contract; (6) in the event of any unauthorized access, destruction, use, modification, disclosure or loss of the personal information (collectively referred to as the "unauthorized use"): (a) immediately notify the contracting agency if the Contractor becomes aware of the unauthorized use; (b) provide full cooperation and access to information necessary for the contracting agency to determine the scope of the unauthorized use; and (c) provide full cooperation and access to information necessary for the contracting agency and the Contractor to fulfill any notification requirements. Breach of these terms may be regarded as a material breach of this Contract, such that the Commonwealth may exercise any and all contractual rights and remedies, including without limitation indemnification under Section 11 of the Commonwealth's Terms and Conditions, withholding of payments, Contract suspension, or termination. In addition, the Contractor may be subject to applicable statutory or regulatory penalties, including and without limitation, those imposed pursuant to G.L. c. 93H and under G.L. c. 214, § 3B for violations under M.G.L c. 66A.

Executive Orders 523, 524 and 526. Executive Order 526 (Order Regarding Non-Discrimination, Diversity, Equal Opportunity and Affirmative Action which supersedes Executive Order 478). Executive Order 524 (Establishing the Massachusetts Supplier Diversity Program which supersedes Executive Order 390). Executive Order 523 (Establishing the Massachusetts Small Business Purchasing Program.) All programs, activities, and services provided, performed, licensed, chartered, funded, regulated, or contracted for by the state shall be conducted without unlawful discrimination based on race, color, age, gender, ethnicity, sexual orientation, gender identity or expression, religion, creed, ancestry, national origin, disability, veteran's status (including Vietnam-era veterans), or background. The Contractor and any subcontractors may not engage in discriminatory employment practices; and the Contractor certifies compliance with applicable federal and state laws, rules, and regulations governing fair labor and employment practices; and the Contractor commits to purchase supplies and services from certified minority or women-owned businesses, small businesses, or businesses owned by socially or economically disadvantaged persons or persons with disabilities. These provisions shall be enforced through the contracting agency, OSD, and/or the Massachusetts Commission Against Discrimination. Any breach shall be regarded as a material breach of the contract that may subject the contractor to appropriate sanctions.

AMENDMENT #20
to

THE MASSHEALTH PCC PLAN'S COMPREHENSIVE BEHAVIORAL HEALTH PROGRAM AND MANAGEMENT SUPPORT SERVICES, AND BEHAVIORAL HEALTH SPECIALTY PROGRAMS CONTRACT

between

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OFFICE OF MEDICAID
1 ASHBURTON PLACE
BOSTON, MA 02108

and

THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP
1000 WASHINGTON STREET
BOSTON, MA 02118

WHEREAS, the Executive Office of Health and Human Services Office of Medicaid (referred to throughout the Contract as either "EOHHS" or "MassHealth") and the Massachusetts Behavioral Health Partnership ("Contractor") entered into a contract, effective October 1, 2012, to provide innovative, cost-effective, high-quality care management services, network management services, quality management activities and comprehensive Behavioral Health Services for certain MassHealth members, including but not limited to a Care Management Program for individual Enrollees with complex medical and/or behavioral health conditions, through a program known as the MassHealth PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs ("BHP MSS Contract" or "Contract"); and

WHEREAS, EOHHS and the Contractor amended the Contract on October 30, 2012 (Amendment #1); April 1, 2013 (Amendment #2); June 28, 2013 (Amendment #3); September 30, 2013 (Amendments #4 and #5); October 31, 2013 (Amendment #6); November 15, 2013 (Amendment #7); March 18, 2014 (Amendment #8); March 27, 2014 (Amendment #9); June 30, 2014 (Amendments #10 and #11); October 24, 2014 (Amendment #12); November 6, 2014 (Amendment #13); December 2, 2014 (Amendment #14); May 4, 2015 (Amendment #15); June 30, 2015 (Amendment #16); July 15, 2015 (Amendment #17), July 31, 2015 (Amendment #18); September 30, 2015 (Amendment #19), and

WHEREAS, in accordance with Section 13.3 of the Contract, EOHHS and the Contractor desire to further amend their agreement effective upon execution of this amendment, in accordance
with the rates, terms and conditions set forth herein; and

WHEREAS, EOHHS and the Contractor agree that the terms stated herein are subject to the approval of the federal Centers for Medicare and Medicaid Services (CMS);

NOW, THEREFORE, in consideration of their mutual undertakings, EOHHS and the Contractor agree to amend the BHP MSS Contract as follows:

SECTION 3 BEHAVIORAL HEALTH NETWORK RESPONSIBILITIES

1. **Section 3.1.B.20(c)(iii)** is hereby amended by deleting it in its entirety and replacing it with the following:

"(iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate for those positions for which the duties are substantially similar to the duties performed by regular agency employees, as follows:

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54{2)
ESP Director	Clinical Social Worker (D) Psychologist IV	Program Director (UFR Title 102)	$62,202.14
QM/ RM Director	Manager VI	Supervising Professional (UFR Title 104)	$52,399.08
Program Manager	Clinical Social Worker (D)	Program Function Manager (UFR Title 101)	$62,202.14
Clinical Super ·	Clinical Social Worker (C) Human Services Coordinator (D)	Supervising Professional (UFR Title 104)	$52,399.08
Nursing Manager RN	Registered Nurse IV Registered Nurse V	N. Midwife, N.P., Psych N.,N.A.,R.N.-MA (UFR Title 107)	$62,225.86
		R.N.-Non-Masters (UFR Title 108)	**$51,552.04**
Nursing RN	Registered Nurse II Community Psychiatric MH Nurse	R.N.-Non-Masters (UFR Title 108)	$51,552.04
Nursing LPN	Licensed Practical Nurse I Licensed Practical Nurse II	L.P.N. (UFR Title 109)	$40,513.20
Certified Peer Specialist	Mental Health Coordinator I	Direct Care/Prag. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prag. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prag. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prag. Staff I (UFR Title 136)	**$27,741.38**
BS w/CPS preferred	Human Services Coard (A/B)	Direct Care/Prag. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prag. Staff III (UFR Title 134)	$36,751.40

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)
		Direct Care/Prag. Staff II {UFR Title 135)	$28,429. 14
		Direct Care/Prag. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu	Mental Health Worker I Mental Health Worker II	Direct Care/Prag. Staff Supervisor {UFR Title 133)	$39,276.49
		Direct Care/Prag. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prag. Staff II {UFR Title 135)	$28,429.14
		Direct Care/Prag. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu W/CPS preferred	Human Services Coordinator (A/B)	Direct Care/Prag. Staff Supervisor {UFR Title 133)	$39,276.49
		Direct Care/Prag. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prag. Staff II (UFR Title 135)	$28,429. 14
		Direct Care/Prag. Staff I (UFR Title 136)	**$27,741.38**
Paraprofessional (Family Partner)	Mental Health Coordinator I	Direct Care/Prag. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prag. Staff III {UFR Title 134)	$36,751.40
		Direct Care/Prag. Staff II {UFR Title 135)	$28,429. 14
		Direct Care/Prag. Staff I (UFR Title 136)	**$27,741,38**
MS Triage Clinician	Human Services Coordinator (C) Social Worker (C)	Case Worker/Manager - Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager {UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinicians	Human Services Coordinator (C)	Case Worker/Manager - Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinician Mobile	Human Services Coordinator (C) Clinical Social Worker (A/B) Clinical Social Worker (C)	Case Worker/Manager - Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
Safety Staff	Mental Health Worker I	Direct Care/Prag. Staff II (UFR Title 135)	$28,429. 14
		Direct Care/Prag. Staff I (UFR Title 136)	**$27,741.38**
Admin. Assistant	Administrative Assistant I Clerk III	Program Secretarial/ Clerical Staff (UFR Title 137)	**$27,543.92"**

SECTION 10 PAYMENT AND FINANCIAL PROVISIONS

1. **Section 10.13.C** is hereby amended by adding a new **subsection 10.13.C** at the end therein as follows:

"D. For calendar year 2014, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after November 1, 2015".

APPENDICES

1. **Appendix H-1, Payment and Risk Sharing Provisions,** is hereby amended by deleting it in its entirety and replacing it with the attached **Appendix H-1, Payment and Risk Sharing Provisions.**

Amendment #20: Appendix H-1, Payment and Risk Sharing Provisions (MassHealth and DMH), is hereby amended by deleting it in its entirety and replacing it with this Appendix H-1, PAYMENT AND RISK SHARING PROVISIONS, Rates for Contract Year Four: Contract Period, July 1, 2015, to June 30, 2016 (FY16).

APPENDIX H-1

PAYMENT AND RISK SHARING PROVISIONS

Rates for Contract Year Four: Contract Period, July 1, 2015, to June 30, 2016 (FY16)

Section 1. MassHealth Capitation Payment

A. Base Per-Member Per-Month (PMPM) Capitation Rates for Contract (pursuant to Section 10.2 of the Contract)

Base PMPM Service and Administrative Capitation Rates

Contract Period -July 1st[1] 2015 to June 30th 2016

Rating Category I Service Component Families and Children excluding Third- Party Liability Children Under 21
Per Member Per Month $61.21
Per Member Per Day $2.02

Rating Category I Administrative Component Families and Children excluding Third-Party Liability Children Under 21
Per Member Per Month $5.40
Per Member Per Day $0.18

Rating Category I Service Component Children Under 21
Per Member Per Month $48.19
Per Member Per Day $1.59

Rating Category I Administrative Component Children Under 21
Per Member Per Month $5.12
Per Member Per Day $0.17

Rating Category II Service Component Disabled Excluding Third-Party Liability Children Under 21
Per Member Per Month $214.10
Per Member Per Day $7.04

Rating Category II Administrative Component Disabled Excluding Third-Party Liability Children Under 21
Per Member Per Month $12.76
Per Member Per Day $0.42

Rating Category II Service Component Children Under 21
Per Member Per Month $116.57
Per Member Per Day $3.83

Rating Category II Administrative Component Children Under 21
Per Member Per Month $10.74
Per Member Per Day $0.35

Rating Category VIII Service Component Money Follows the Person (MFP)
Per Member Per Month $94.0l
Per Member Per Day $3.09

Rating Category VIII Administrative Component Money Follows the Person (MFP)
Per Member Per Month $5.37
Per Member Per Day $0.18

Rating Category IX Services Component
Per member per month $65.54

Rating Category IX Administrative Component
Per member per month $4.40

Rating Category X Services Component
Per member per month $268.61

Rating Category X Administrative Component
Per Member Per month $12.61

Applied Behavior Analysis (ABA) Rates effective October 1, 2015 through June 30, 2016:

Rating Category	FY16 ABA add on rate (PMPM)	PMPD
Rating Category I:	$ 0.35	$0.01
Rating Category I TPL:	$ 1.14	$0.03
Rating Categorv II:	$ 0.89	$0.04
Rating Category II TPL:	$ 7.42	$0.24

C. Risk Sharing Corridors for Contract Year Four, July 1, 2015, to June 30, 2016, forthe Service Component of Rating Categories I, I-TPL, II, 11-TPL, IX, and X (pursuant to Section 10.6 of the Contract)

1. Gain on the Base PMPD Capitation Rates excluding ABA services

The amount of the Gain on the Aggregate Base PMPD Capitation Rates for the Contract shall be defined as the difference between the Total Base PMPD Capitation

Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are less than the Total Base PMPD Capitation Payment for Contract Year Four.

Gain	MassHealth Share	MBHP Share
Between O and 2% of gain	0%	100%
>2% of gain	100%	0%

2. Loss on the Base PMPD Capitation Rates excluding ABA services

The amount of the Loss on the Base PMPD Capitation Rates for the Contract shall be defined as the difference between the Total Base PMPD Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are greater than the Total Base PMPD Capitation Payment for Contract Year Four.

Loss	MassHealth Share	Contractor Share
Between O and 2% ofloss	0%	100%
>2% ofloss	100%	0%

D. Risk Sharing Corridors for Contract Year Four effective October 1, 2015 through June 30, 2016, for ABA Services:

The Contractor and EOHHS shall share risk for ABA Services in accordance with thefollowing provisions:

1. For Contract Year 2016, EOHHS shall conduct a separate reconciliation with respect to ABA Services, as follows:
   a. EOHHS will first determine the amount paid to the Contractor by EOHHS for ABA Services for Contract Year 2016 effective October 1, 2015 by multiplying the following:
      i. The ABA Add-On to the applicable Base Capitation Rates, determined by EOHHS and provided to the Contactor in Section 1.A above; by
      ii. The number of member months for the period October 1, 2015 through June 30th 2016.
   b. EOHHS will then determine the Contractor's adjusted expenditures for ABA Services for Contract Year 2016 effective October 1, 2015 by multiplying the following:
      i. The number of service units provided by the Contractor with respect to ABA Services, which shall be determined by the claims data submitted in the report described in Section C.2 below and by Encounter Data submitted by the Contractor; by

ii. The applicable rate for each of the ABA Services, as established by EOHHS.

If the amount paid to the Contractor, as determined by the calculation described in Section C.1.a above, is greater than the Contractor's adjustedexpenditures, as determined by the calculation described in Section C.l.b above, then the Contractor shall be considered to have experienced a gain with respect to ABA Services for Contract Year 2016. EOHHS and the Contractor shall share such gain in accordance with the table below:

Gain	MassHealth Share	Contractor Share
Between $0 and $100,000 of gain	99%	1%
> $100,000 gain	100%	0%

If the amount paid to the Contractor, as determined by the calculation described in Section C.1.a above, is less than the Contractor's adjusted expenditures, as determined by the calculation described in Section C.1.b. above, then the Contractor shall be considered to have experienced a loss with respect to ABA Services for Contract Year 2016. EOHHS and the Contractor shall share such loss in accordance with the table below:

Loss	MassHealth Share	Contractor Share
Between $0 and $100,000 of loss	99%	1%
> $100,000 ofloss	100%	0%

2. To assist with the reconciliation process for ABA Services described above, the Contractor shall, within 180 days after the end of Contract Year 2016, submit claims data with respect to ABA Services in the form and format specified in Appendix E.

Section 5. MassHealth Other Payments

A. Care Management Program

The Contractor shall calculate and report on the number of Participants in Care Management on a monthly basis and shall be paid an Engagement PPPM, upon EOHHS review and approval, on a quarterly basis.

Base Per-Participant Per-Month (PPPM) Rate for Care Management Contract.

Engagement:

Per Participant Per Month $150.00

B. Performance Incentives Arrangements

Total Payments for Performance Incentive Arrangements may not exceed 105 percent of approved Capitation Payments attributable to the Enrollees or services covered by the Contract.

1. The Care Management Outcome Incentives Payment for Contract Year Four will be a total of $2,000,000.
2. The Pay-For-Performance Incentive Arrangement for Contract Year Four will be $2,000,000.

Annual payment for performance, where earned, will be based on actual performance improvement no earlier than six months following the end of the calendar year of the measurement, as illustrated in the table below.

Baseline Measurement Year (Calendar Year)	Performance Measurement Year (Calendar Year)	Payment
CY15	CY16	July 2017

3. The ABA incentive payment for Contract Year Four for the period October 1, 2015, through June 30, 2016 will be $300,000.

Performance measurement period	Payment timeline
October 1 , 2015- June 30, 2016	First quarter of calendar year 2016

C. PCC Plan Management Support

Base Per-Member (Enrollees) Rate for PCC Plan Management Support

Per Participant Per Month $1.25
Per Participant Per Day $0.04l

Section 3. DMH Compensation Payments (Non-MassHealth Payments)

A. DMH Payments for the Contract (pursuant to Section 10.9 of the Contract)

The Contract Year Four DMH Compensation Payment shall be $12,589,810.00.

B. DMH ESP Program for Uninsured Individuals Service Compensation Rate Payment (pursuant to Sections 3.4, 10.9 and 10.10 of the Contract)

The DMH ESP Program for Uninsured Individuals Service Compensation Rate Payment shall consist of the following amounts:

1. The Contract Year Four amount shall be $6,700,000.

2. The monthly payment shall be $558,333.33.

C. DMH ESP expansion - Safety initiatives:
   1. The DMH ESP safety initiative payment shall be $1,403,388.
   2. The monthly payment amount shall be $116,949.00.

D. DMH Specialty Program Administrative Compensation Rate Payment (pursuant to Section 10.9.A of the Contract)

The DMH Specialty Program Administrative Compensation Rate Payment shall be $609,000 for Contract Year Four.

1. Indirect Costs shall not exceed 3.5% of Direct Costs.
2. The total of Direct Costs plus Indirect Costs shall not exceed $572,000.
3. Earnings shall be 6.6% of the total direct and indirect costs
4. Earnings shall be $37,000 for the Contract Year Four.
5. The amount of the monthly DMH Specialty Program Administrative Compensation Rate Payment shall be $50,750.

E. DMH Payments for Forensic Services and other Forensic Evaluations (pursuant to Sections 4.6 and 10.9.B of the Contract)
   1. The Forensic Evaluations (known as "18(a)") Amount for the Contract Year Four shall be $210,000.
   2. The Contractor shall return to EOHHS any portion of the DMH Payments for Forensics Services amount that it does not spend on Forensic Evaluations as identified in the annual reconciliation of the Contract Year Four within 60 days of the identification of such under spending unless otherwise agreed to by the parties.

F. Massachusetts Child Psychiatric Access Project (pursuant to Section 10.9.A of the Contract)
   1. The DMH Payment for MCPAP for Contract Year Four shall be $3,600,000.
   2. The monthly payment for the DMH Payment for MCPAP shall be $300,000.00.

      The Contractor shall return to EOHHS any portion of the DMH Payment for MCPAP that it does not spend on the MCPAP identified in the annual reconciliation of the contract between the parties (the PCC Plan's Behavioral Health Program Contract) for Contract Year Four, within 60 days of the identification of such unspent portion unless otherwise agreed to by the parties.

G. Race to the Top Award

The DMH payment for Race to the Top for Contract Year Four shall be $67,422 for a six month period, through December 31, 2015.

H. State Innovation Model Initiative Grant

The EOHHS State Innovation Model Initiative for the first test year (through calendar year 2015) payments for Contract Year Four shall be $291,274.

Section 4. Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP) Payment Provisions

Subject to appropriation, each Contract Year, EOHHS shall pay the Contractor $35,476.00 for each of the Contractor's ESPs that contract with the Contractor to operate the MCI/RAP in accordance with Section 4.9 not to exceed a maximum of $603,092.00.

Exhibit 1: Adjustment to Base Capitation Rates to Account for the Health Insurer ProviderFee (HIPF) under Section 9010 of the ACA

For the HIPF for calendar year 2014, EOHHS shall:

1. Perform the following retrospective add-on adjustment to the Contract Year Two Capitation Rates, as reflected in the Appendix H-1 effective during that period (as incorporated into this Contract through Amendment 7). Such adjustmnt shall be applied to the period of January 1, 2014 -June 30, 2014.

Table I : Health Insurer Fee Add-on Rate (January 1, 2014, through June 30, 2014)

Rating Category	Adjustment PMPD
RCI	$ 0.09
RCII	$ 0.21
TPL-RCI	$ 0.04
TPL-RCII	$ 0.17

2. Perform the following retrospective add-on adjustment to the Contract Year Three Capitation Rates, as reflected in the Appendix H-1 effective during that period (as incorporated into this Contract through Amendment 11). Such adjustment shall be applied to the period of July I , 2014 – December 31, 2014.

Table 2: Health Insurer Fee Add-on Rate (July I , 2014, through December 31, 2014)

Rating Category	Adjustment PMPD
RCI	$ 0.05
RCII	$ 0.24
TPL-RCI	$ 0.05
TPL-RCII	$ 0.15

EMERGENCY SERVICES PROGRAM AGREEMENT

This Emergency Services Program Agreement (the "Agreement") is made this ____ day of ____, 20__, by and between the Massachusetts Behavioral Health Partnership, a Massachusetts general partnership with principal offices at 1000 Washington Street, Suite 310, Boston, Massachusetts ("MBHP") and _____, a Massachusetts _____ with its principal place of business at _____ ("Provider") (collectively referred to herein as the "parties" or individually referred to as a "party").

R E C I T A L S

WHEREAS, employees of the Commonwealth of Massachusetts Department of Mental Health ("DMH") currently provide services related to the Emergency Services Program ("ESP) in the southeastern region of the state;

WHEREAS, the Massachusetts Executive Office of Health and Human Services ("EOHHS") desires to privatize ESP services in southeastern Massachusetts pursuant to the state's Privatization Law by contracting with an appropriate and qualified third party to provide ESP services for the southeastern of the state;

WHEREAS, MBHP has entered into a contract with EOHHS to arrange for the provision of certain behavioral health services to individuals in Massachusetts and which requires MBHP to administer certain emergency service programs (the "PCC Plan Contract");

WHEREAS, EOHHS amended the PCC Plan Contract to authorize MBHP to issue a Request for Response dated July 6, 2015 ("RFR") relating to the procurement of ESP services in southeastern Massachusetts;

WHEREAS, MBHP selected Provider as the successful bidder to provide ESP Services based on Provider's response to the RFR (the "RFR Submission"); and

WHEREAS, Provider is qualified and willing to perform its duties as set out in this Agreement.

NOW, THEREFORE, in consideration of the promises, mutual covenants, agreements and other good and valuable consideration herein contained, receipt and sufficiency of which is hereby acknowledged, MBHP and Provider mutually agree as follows:

SECTION 1 DEFINITIONS

1.1 Definitions.

"Catchment Area" shall mean the catchment area identified on MBHP's ESP Directory as posted on the MBHP web site at http://www.masspartnership.com.

"Eligible Individual" means any individual of any age who is in need of ESP Services within the Catchment Area, including individuals up to age twenty-one (21) in need of Mobile Crisis Intervention, and individuals aged twenty-one (21) and over in need of Adult Mobile Crisis Intervention, and individuals aged eighteen (18) and over in need of Community Crisis Stabilization.

"Encounter" means the provision by the Provider of any single service or combination of services as described in the General Performance Specifications as well as the Performance Specifications for the Emergency Services Program, Adult Community Crisis Stabilization, and Mobile Crisis Intervention, all of which are part of the MBHP Provider Manual which is an extension of this Agreement. "Encounter" also includes any single service or combination of services as described in the program service list for the Mobile Crisis Intervention/Runaway Assistance Program, attached as Exhibit A.

"ESP Services" means emergency behavioral health crisis assessment, intervention and stabilization, including all services required by an individual until an acute behavioral health crisis has been stabilized or until the individual can be safely referred or transferred to another appropriate level of care, and as further defined in the General Performance Specifications as well as the Performance Specifications for the Emergency Services Program, Adult Community Crisis Stabilization, and Mobile Crisis Intervention, all of which are part of the MBHP Provider Manual which is an extension of this Agreement. "Encounter" also includes any single service or combination of services as described in the program service list for the Mobile Crisis Intervention/Runaway Assistance Program, attached as Exhibit A.

"HIPAA Rules" means those laws and regulations relating to and/or promulgated under the Health Insurance Portability and Accountability Act of 1996, including, but not limited to, 45 CFR Parts 160 and 164.

"Privatization Law" means the Massachusetts statute codified at M.G.L. c.7, §§52, 53, 54, 55 which outlines the process the state must use when seeking to privatize services provided by state employees and the requirements to which successful bidders must adhere when awarded a privatization contract under this law.

"System of Care" means an integrated system of behavioral health services with strong linkages to non-acute components of the behavioral health system and other service systems as described in the RFR Submission.

SECTION 2 STATEMENT OF PURPOSE

2.1 Purpose of Agreement. MBHP and Provider enter into this Agreement to set forth the parties' obligations for the operation and success of the ESP. Provider shall be responsible for providing ESP Services for the _____ catchment area(s) in a clinically appropriate manner that offers a culturally and linguistically competent spectrum of emergency behavioral health services as set forth in this Agreement. Provider shall establish a community-based program aimed at directing Eligible Individuals to appropriate venues for the receipt of crisis behavioral health services other than Emergency Departments ("EDs") when Eligible Individuals are not in need of ED care or do not voluntarily seek care in that setting.

2.2 Order of Precedence. Provider's response to MBHP's RFR served as the basis for this Agreement and is incorporated by reference into the Agreement. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

(a) this Agreement, including all Exhibits, any amendments, and the MBHP Provider Manual pursuant to Section 8.1 of this Agreement;

(b) the RFR; and

(c) the provider's RFR Submission.

SECTION 3 DATA MANAGEMENT AND REPORTING

3.1 Data Management System Capability. Provider shall implement appropriate systems to adequately track data regarding the ESP Services provided to Eligible Individuals ("Data Management Systems"). Such systems are to include, but not be limited to: a) a client management information system; and b) clinical tracking and utilization software. Provider shall be responsible for maintaining the appropriate hardware and software necessary to operate these systems. All Data Management Systems shall be subject to MBHP's reasonable approval. Provider agrees to communicate with MBHP and to modify its Data Management Systems to track ESP Service information as requested by MBHP. Provider shall have sole ownership of the Data Management Systems.

At a minimum, Provider shall use its Data Management Systems to catalogue and manage Eligible Individual data including demographic information, medications and Eligible Individual encounter information.

Provider shall comply at all times with HIPAA Rules. Data Management Systems shall also be designed to allow Provider to comply with applicable required state or federal reporting and documentation requirements.

3.2 Report Generation. The Data Management Systems shall be capable of providing reports required pursuant to this Agreement including, but not limited to, tracking financial data, claims processing and billing, demographics, insurance information, current charges, payments, claim rejections, and outstanding balances at the invoice or service line item level.

SECTION 4 PAYMENT AND FINANCIAL PROVISIONS

For services provided pursuant to this Agreement, MBHP shall pay Provider in accordance with the terms set forth in Exhibit C attached hereto. In the event that MBHP reviews the ESP Services provided by Provider and determines that such services were not provided pursuant to this agreement, MBHP may retroactively deny payment and recoup or offset those amounts that should not have been paid. Any such action by MBHP shall be subject to your rights of appeal set forth in the Administrative Operations section of the Provider Manual.

SECTION 5 MBHP RESPONSIBILITIES AND OVERSIGHT

5.1 Administrative Responsibilities.

(a) MBHP Contact Personnel. MBHP shall designate a primary contact person to act as liaison between Provider and MBHP for the duration of the Agreement. MBHP may change its designation of primary contact person at any time during the Agreement and shall provide Provider with notification of any such change. The primary contact person shall be authorized to represent MBHP in all programmatic and operational aspects of the Agreement.

(b) MBHP Provision of Data. MBHP shall provide Provider with available information and data in its possession as necessary for the successful performance of the Agreement. MBHP shall not be responsible for providing Provider with any information in violation of any federal or state laws and MBHP shall have discretion with regard to providing Provider with any information that it deems to be confidential so long as Provider does not require such information to meet its contractual obligations hereunder.

(c) Report Review. MBHP shall review Provider's submitted reports and shall reserve the right to request additional reports that MBHP deems necessary for monitoring and evaluating the performance of Provider.

5.2 Performance Evaluation.

MBHP shall:

(a) At its discretion, upon reasonable notice during normal business hours, perform periodic programmatic and financial reviews. These may include on-site inspections and audits by MBHP or its agents of the records of Provider relating to the ESP.

(b) Provide reasonable notice to Provider prior to any on-site visit to conduct an audit, and further notify Provider of any records MBHP wishes to review.

(c) Review and evaluate Provider for its successful performance of all contractual obligations and its compliance with the terms of the Agreement.

(d) Inform Provider of the results of any performance evaluations and of any dissatisfaction with Provider's performance, and reserve the right to demand a corrective action plan as set forth in the Section 8.7 or to terminate the Agreement in accordance with Section 6.3 of this Agreement.

SECTION 6 TERM AND TERMINATION

6.1 Term. This Agreement shall be effective for the period from _____ (the "Effective Date") through June 30, 2017 (the "Initial Term") and automatically renew for successive one (1) year terms (each a "Renewal Term") unless either party provides advance written notice of its intent to not renew the Agreement at least ninety (90) days prior to the expiration of the then current term.

6.2 Immediate Termination. MBHP may terminate the Agreement immediately and without prior written notice upon any of the events listed below. If MBHP determines to terminate the Agreement under this Section, it shall notify Provider in writing of the effective date of termination within five (5) business days of its determination.

(a) Provider's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;

(b) Provider's admission in writing that it is unable to pay its debts as they mature;

(c) Provider's assignment for the benefit of creditors;

(d) Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against Provider in any such proceeding;

(e) Commencement of an involuntary proceeding against Provider under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within sixty (60) days;

(f) Provider loses any state or federal licenses, accreditations or approvals required to perform services under this Agreement;

(g) Cessation in whole or in part of state or federal funding of the Emergency Services Program as contemplated in the BHP Contract; or

(h) MBHP determines in its sole discretion that the health, safety or welfare of Eligible Individuals requires immediate termination of the Agreement and provides Provider with a detailed description of the facts upon which it has based its determination.

6.3 For Cause Termination.

(a) MBHP may terminate the Agreement for cause based upon material breach of this Agreement by Provider, provided that MBHP shall give Provider written notice specifying the breach and shall afford Provider a reasonable opportunity to correct the breach. If within thirty (30) days after receipt of notice Provider has not corrected the breach or, in the case of a breach which cannot be corrected within thirty (30) days, begun and proceeded in good faith to correct the breach, MBHP may declare Provider in default and terminate the contract effective immediately.

(b) Provider may terminate the Agreement for cause based upon MBHP's failure to make payments when due hereunder, provided that Provider shall give MBHP written notice specifying that payment is late and shall afford MBHP a period of fifteen (15) business days to make payment. If within fifteen (15) days after receipt of notice MBHP has not made payment on all amounts due, Provider may declare MBHP in default and terminate the contract effective immediately.

6.4 Termination Without Cause. MBHP may terminate this Agreement at any time for any reason upon sixty (60) days advance written notice to the Provider.

6.5 Continued Obligations. In the event of termination, expiration or nonrenewal of the Agreement, the obligations of the parties hereunder with regard to Eligible Individuals at the time of termination, expiration or nonrenewal shall continue until the Eligible Individuals no longer require ESP Services. Provider agrees to cooperate with MBHP with regard to the transition of the ESP and ESP Services to another provider as needed. Such transitional services shall include communication with the subsequent provider of ESP Services regarding Eligible Individual data as appropriate and continued provision of ESP Services during any reasonable startup period of the subsequent provider. Any ESP Services provided by Provider following termination of this Agreement in accordance with any transition provisions of this Agreement shall be reimbursed in accordance with the financial terms in effect for the current agreement year at the time of the termination.

SECTION 7 TERMS AND CONDITIONS PURSUANT TO THE MASSACHUSSETTS PRIVATIZATION LAW

7.1 Employee Recruitment. Provider shall offer available employee positions to qualified regular or former DMH employees provided that such employees were terminated because of the privatization of ESP services through this contract and such employees satisfy the hiring criteria of the Provider.

7.2 Health Insurance Coverage and Contributions. Provider shall provide health insurance coverage to every employee employed for not less than twenty hours per week pursuant to this contract. Such health insurance shall also cover the employee's spouse and dependent children. Provider shall pay not less than seventy-five percent (75%) of the cost of health insurance for every employee and employee family member so covered.

7.3 Minimum Wage. For each position in which the Provider will employ any person to perform work in which the duties are substantially similar to the duties performed by regular DMH employees, Provider shall pay to these employees no less than the minimum wage summarized in Exhibit E for such positions.

7.4 Non-discrimination. The Provider agrees to comply with the nondiscrimination and equal opportunity mandates summarized in M.G.L. c. 151B.

7.5 Reporting. Provider shall submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services pursuant to this contract. Such reporting shall be due to EOHHS no later than thirty (30) days following the end of each quarter of the contract. Reports must be submitted to EOHHS.

7.6 Certifications. By signing this Agreement, the Provider certifies that the Provider and any of the Provider's supervisory employees, while in the employ of the Provider, have no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute, including, but not limited to, statutes concerning labor relations,

occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest.

7.7 Applicability. Provider must comply with the terms outlined in Sections 7.1, 7.2, 7.3 and 7.5 through the end of the Initial Term of this Agreement. Section 7.1, 7.2, 7.3 and 7.5 do not apply to any Renewal Term of this Agreement.

SECTION 8 ADDITIONAL TERMS AND CONDITIONS

8.1 Provider Manual. The MBHP Provider Manual setting forth MBHP's procedures is deemed to be part of this Agreement. A copy of the Provider Manual shall be available on MBHP's website and in hard copy, upon request. MBHP will notify Provider of any amendments to the Manual via Provider Alerts. Any such amendments to the Provider Manual will be forwarded to Provider by mail or electronically no less than thirty (30) days (or such lesser period of time as required by applicable law) prior to the date they take effect. The content of all Provider Alerts is incorporated by reference into the Provider Manual and supersede those provisions of the Manual that are inconsistent with such content.

8.2 Prohibited Affiliations. In accordance with 42 U.S.C. § 1396 u-2(d)(1), Provider shall not knowingly have an employment, consulting or other agreement for the provision of items and services that are significant and material to Provider's obligations under the Agreement with any person or entity who is excluded under federal law or regulation from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of Provider's equity, nor be permitted to serve as a director, officer or partner of Provider.

8.3 Disclosure Requirements. Provider shall disclose to MBHP and to the U.S. Department of Health and Human Services information on ownership and control, business transactions, and persons convicted of crimes in accordance with 24 CFR Part 455, Subpart B. In addition, Provider shall comply with all reporting and disclosure requirements of 42 U.S.C. §1396 b(m)(4)(A) if Provider is not a federally qualified health maintenance organization under the Public Health Service Act.

8.4 Agreement Compliance. Provider shall immediately notify MBHP of any occurrence that affects Provider's ability to operate and comply with all or any material part of its responsibilities under the Agreement, along with an assessment of the time and effort necessary to recover.

8.5 Compliance With Laws. Each of the parties shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to its property and the conduct of operations as they become effective.

8.6 Loss of Licensure. Provider shall report to MBHP if at any time during the Agreement Provider or any material subcontractor loses any applicable license, state approval or accreditation. Such loss shall be grounds for termination of the Agreement under the provisions of Section 6.2.

8.7 Corrective Action Plan. If, at any time, MBHP determines that Provider is deficient in the performance of its obligations under the Agreement, MBHP may require Provider to develop and submit a corrective action plan that is designed to correct such deficiency. MBHP shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. Provider shall, upon approval of MBHP, immediately implement the corrective action plan, as approved or modified by MBHP. Provider's failure to implement any corrective action plan may, in the sole discretion of MBHP, be considered breach of the Agreement, subject to any and all contractual remedies including termination of the Agreement with or without notice.

8.8 Privacy and Confidentiality Requirements. MBHP and Provider shall comply with the terms and conditions of the Privacy and Confidentiality Obligations attached hereto as Exhibit D and made a part hereof. Provider shall designate a custodian of Personal Data, as defined in Exhibit D, who will be responsible for assuring Provider's compliance with all requirements set forth in the Agreement relating to Personal Data, and shall notify MBHP of the identity of the designated custodian in advance of the Effective Date and whenever a change occurs.

8.9 Medical Records.

Provider shall:

(a) Comply with any and all state and federal statutory and regulatory requirements applicable to medical records and protected health information including the requirements set forth in the HIPAA Rules and Massachusetts General Laws, Chapter 66A. In addition, Provider shall at a minimum maintain medical records in a manner that is current, detailed, and organized and that permits effective patient care and quality review and maintain information sufficient to satisfy Section 5 of this Agreement.

(b) Ensure that medical records include sufficient information to identify the Eligible Individual, date of encounter and pertinent information that documents the Eligible Individual's diagnosis; and

(c) Ensure that medical records describe the appropriateness of the treatment and services, the course and results of the treatment and services.

8.10 Recordkeeping, Audit and Inspection of Records. Provider shall maintain books, records and other compilations of data pertaining to the performance of the provisions and requirements of the Agreement to the extent and in such detail as shall properly substantiate claims for payment under the Agreement. All such records shall be kept for a period of six (6) years.

MBHP, or its duly authorized representatives or designees shall have the right at reasonable times and upon reasonable notice to examine and copy the books, records and other compilations of data of Provider which pertain to the provisions and requirements of this Agreement, and to evaluate through inspection or other means the quality, appropriateness and timeliness of services performed by Provider under the Agreement.

8.11 Assignment. Neither party shall assign or transfer any right or interest in the Agreement to any successor entity or other entity without the prior written consent of the other party;

provided, however, that in the event the Commonwealth of Massachusetts requires MBHP to assign or transfer any of its rights or interest hereunder to the Commonwealth or to another party, consent by Provider shall not be required.

8.12 Use and Ownership of Data.

(a) MBHP Rights. All data acquired by Provider from MBHP in the performance of the Agreement (including Personal Data) remain under the control of MBHP. MBHP shall be given full access at all reasonable times to all such data. All finished or unfinished studies, analyses, flow charts, magnetic tapes, design documents, program specifications, programs, computer source codings and listings, test data, test results, schedules and planning documents, training materials and user manuals, forms, reports, and any other documentation and software, including modifications thereto, prepared, acquired, designed, improved or developed by Provider for delivery to MBHP under the Agreement shall be and remain the property of MBHP.

(b) Contractor Limitations

Provider shall:

(1) Not disseminate, reproduce, display or publish any report, map, information, data or other materials or documents produced in whole or in part in satisfaction of its obligations under this Agreement without the prior written consent of MBHP, nor shall any such report, map, information, data or other materials or documents be the subject of an application for patent or copyright by or on behalf of Provider without the prior written consent of MBHP.

(2) Use MBHP-owned data, materials and documents, before or after termination or expiration of the Agreement, only as required for the performance of the Agreement.

(3) Return to MBHP promptly, but in any event no later than one (1) week after MBHP's request, EOHHS-owned or Commonwealth-owned data, materials and documents, in whatever form they are maintained by Provider.

8.13 Indemnification. Provider shall indemnify and hold harmless MBHP and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which MBHP or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with Provider's violation of any federal or state law or regulation or any negligent action or inaction or willful misconduct of Provider, or any person employed by Provider except such as may result from the negligent or wrongful acts or omissions of MBHP or the Commonwealth or its agents, employees or contractors, provided that:

(a) Provider is notified of any claims within a reasonable time from when MBHP becomes aware of the claim;

(b) Provider is afforded an opportunity to participate in the defense of such claims; and

(c) Provider shall not be responsible for the settlement of any claim, demand or lawsuit made by MBHP or the Commonwealth without Provider's written consent.

8.14 Public Communications Protocol. Provider and MBHP shall exercise best efforts to coordinate any statements in response to any media inquiry concerning the ESP and to collaborate with each other when making any public comment in connection with the ESP.

8.15 Insurance For Employees. Provider shall maintain at its expense all insurance required by law for those employees responsible for providing services under this Agreement and provide MBHP with certification of same prior to the Effective Date and by August 1 of each subsequent year.

8.16 Non-Solicitation. Provider shall not solicit and shall ensure that its wholly owned or controlled subsidiaries shall not solicit Eligible Individuals who are enrolled on the Primary Care Clinician Plan of the MassHealth program to join any other health plan. Any such solicitation shall be deemed a material breach of this Agreement and constitute cause for termination. Nothing in this Section shall be construed to limit Provider from discussing with Eligible Individuals who are Provider's patients the terms of the individual's benefits and coverage under their health plan, nor shall Provider be limited from engaging in general marketing or advertising of their health plan participation to Medicaid recipients.

8.17 Counterparts. The Agreement may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

8.18 Entire Agreement. Except as provided in Section 8.19, the Agreement constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations and undertakings not set forth or incorporated herein. The terms of the Agreement shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein.

8.19 Correction of Omissions, Ambiguities, and Manifest Errors. The parties shall negotiate in good faith to cure any omissions, ambiguities, or manifest errors in the Agreement. By mutual agreement, Provider and MBHP may amend the Agreement where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by both parties, and attached to the Agreement.

8.20 No Third-Party Enforcement. This Agreement is entered into by and between the parties hereto and for their sole benefit. There is no intent by either party to create or establish a third-party beneficiary status, or to create any rights in or confer any benefits upon any person or entity not a party to this Agreement (except for such rights as are expressly created and set forth in this Agreement). Except for the foregoing, no third-party shall have any right to enforce or to enjoy any benefit or obligation created or established under this Agreement.

8.21 Section Headings. The headings of the sections of the Agreement are for convenience only and do not affect the construction hereof.

8.22 Waiver. Either party's acceptance or approval of any materials, including those materials submitted in relation to the Agreement, shall not constitute waiver of any requirements of the Agreement.

8.23 Effect of Invalidity of Clauses. If any clause or provision of the Agreement is in conflict with any state or federal law or regulation, that clause or provision shall be null and void; any such invalidity shall not affect the validity of the remainder of the Agreement.

8.24 Remedies. Nothing in this Agreement shall be construed to waive or limit any of MBHP's or Provider's legal rights or remedies which may arise from MBHP's or Provider's unauthorized use or disclosure of any data received by it under the Agreement.

8.25 Interpretation. Any ambiguity in this Agreement shall be resolved to permit the parties to comply with the HIPAA Rules, and any other applicable law pertaining to the privacy, confidentiality, or security of PHI or Personal Data.

8.26 Written Notices. Notices to the parties as to any Agreement matter will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand as follows:

To Provider:

_____
_____
_____

To MBHP:

_____
Massachusetts Behavioral Health Partnership
1000 Washington Street
Suite 310
Boston, Massachusetts 02118-5002

[Signature Page Follows]

IN WITNESS WHEREOF, intending to be legally bound, the undersigned have caused this Agreement to be duly executed on their behalf as of the dates specified.

MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP	[PROVIDER]
BY: _____	BY: _____
_____	_____
Name	Name
_____	_____
Title	Title

EXHIBIT A
PROGRAM SERVICES
MOBILE CRISIS INTERVENTION/RUNAWAY ASSISTANCE PROGRAM

Mobile Crisis Intervention/Runaway Assistance Program

1. Definitions.

"Alternative Lock-Up Program (ALP)" shall mean human services agencies contracted with the Commonwealth of Massachusetts Department of Children and Families (DCF) to provide a temporary placement resource for the Commonwealth of Massachusetts state and local police departments in their efforts to comply with federal and state regulations regarding the placement of juveniles in their custody for either status or non-violent delinquent offenses.

"Child Requiring Assistance" shall mean a child between the ages of 6 and 18 who: (i) repeatedly runs away from the home of the child's parent, legal guardian or custodian; (ii) repeatedly fails to obey the lawful and reasonable commands of the child's parent, legal guardian or custodian, thereby interfering with their ability to adequately care for and protect the child; (iii) repeatedly fails to obey the lawful and reasonable regulations of the child's school, (iv) is habitually truant; or (v) is a sexually exploited child.

"Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP) Site" shall mean the site the Provider maintains to operate the MCI/RAP.

"Non-Court Hours" shall mean hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically Monday through Friday between 4:30 PM and 8:30 AM, weekends and holidays.

"Youth" shall mean any Child Requiring Assistance or any minor between the ages of 7 and 18 who has been arrested by the police for a non-violent offense.

2. Provider Obligations.

A. The Provider shall establish a Mobile Crisis Intervention/Runaway Assistance Program ("MCI/RAP") to provide a temporary and safe place for Youth to stay on a voluntary basis, until such Youth is transferred to an Alternative Lock-up Program or other appropriate level of service.

B. The Provider shall:

i. Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.

ii. Maintain an MCI/RAP Site where police can bring Youth during Non-Court Hours.

iii. Greet police officers and Youth who come to the MCRI/RAP Site during Non-Court Hours;

iv. Supervise at least on a one-to-one basis until the Youth:
   a. Is transferred to a hospital level of care;
   b. Is transferred to the care of ALP staff; or
   c. Voluntarily leaves the site.

v. If a Youth who is brought to the MCI/RAP Site chooses to voluntarily leave:
   a. Immediately notify the police department of the city or town where the MCI/RAP Site is located and the DCF (if the Youth is known to be in DCF custody);
   b. Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123 §12, and, if determined appropriate, apply for hospitalization of such Youth; and
   c. Submit a critical incident report form to MBHP.

vi. Designate a manager to oversee the MCI/RAP.

C. The MCI/RAP manager designated by the Provider shall oversee the MCI/RAP and shall also:

i. Ensure the MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court ours and be available to MCI/RAP staff for consultation;

ii. Provide back-up coverage for on-call MCI/RAP staff;

iii. Train program staff regarding MCI/RAP procedures;

iv. Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP; and

v. On the business day following the arrival or transfer of a Youth, follow up with the police department that transported the Youth to the MCI/RAP site, and follow-up with any ALP to which the Youth was transferred.

D. Provider shall provide quarterly and annual reports to MBHP in a form designated by MBHP on outcomes and outputs related to the MCI/RAP, including, but not limited to:

i. The number of Youth who receive a crisis intervention assessment;

ii. Demographics related to Youth served including, but not limited to, age, gender, ethnicity and city/town of residence;
iii. The number of Youth unable to be maintained safely at the MCI/RAP site and who require further assessment in the secure environment of the emergency department;
iv. The number of Youth transferred to the care of ALP staff; and
v. The number of Youth who voluntarily leave the MCI/RAP Site.

EXHIBIT B
CORE STAFFING PATTERN

Position	FTEs by service component					
	ESP mgmt.	***Comm.-based location***	***Adult mobile***	***Child mobile***	***Adult CCS***	***Total***
Estimated encounters	n/a	1,065	1,597	710	1,526	4,898
ESP Director	1.0					1.0
QM/ RM Director	0.4					0.4
Program Manager				1.0		1.0
Clinical Supervisor		0.4	0.7			1.1
Psychiatry		0.3		0.2	0.3	0.8
Psychiatry After-Hours Adult Consult		x				
Psychiatry After-Hours Child Consult				x		
Nursing Manager RN					1	1
Nursing LPN					3.2	3.2
Certified Peer Specialist		1.0				1.0
BS w/CPS preferred			0.5			0.5
BS Milieu w/CPS pref.					4.2	4.2
Paraprofessional (Family Partner)				1.7		1.7
MS Triage Clinician		1.0				1.0
MS Clinicians		2.0			1.5	3.5
MS Clinician Mobile			3.5	1.7		5.2
Safety Staff		1.4		cu		1.4
Admin. Assistant	0.5	0.5			0.3	1.3
Total FTE	1.9	6.6	4.7	4.6	10.5	28.3

This is the staffing pattern included in the ESP cost projections for an average size ESP within the medium volume range. A medium volume ESP is one with volume ranging from approximately 3,000 to 6,000 encounters including MBHP, MassHealth FFS (non-MCE), Medicare/Medicaid, MassHealth MCEs, Uninsured, DMH-only, Medicare-only and all One Care and Care Plus plans.

The above shaded positions will likely vary based on actual volume of each of the ESPs. The remaining positions would be expected to increase slightly for “large volume” ESPs over 6,000 encounters and decrease for “small volume” ESPs, projected to be under 3,000.

EXHIBIT C
COMPENSATION TERMS

MBHP provider reimbursement rates are proprietary information. Rate schedules will be added to this exhibit prior to execution of the provider contract.

EXHIBIT D

Privacy and Confidentiality Obligations

Section 1. Provider's Obligations. (a) Provider shall not use or disclose Protected Health Information ("PHI") other than as permitted or required by this Exhibit D or as required by law, consistent with the restrictions of 42 CFR §431.306(f) and M.G.L. c. 66A. Provider is MBHP's Business Associate for purposes of providing services in connection with the Emergency Services Program pursuant to the Agreement. All references to PHI set forth in this Exhibit D shall be limited to PHI in Provider's possession or control solely as a result of providing administrative services pursuant to the Agreement. The purpose of this Exhibit D is to comply with the Business Associate requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA") and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended) (the "Privacy Rule"). Unless otherwise defined in the Agreement, all capitalized terms in this Exhibit D shall have the meaning given in the Privacy Rule.

(b) Provider acknowledges that in the performance of the Agreement it will receive Personal Data as defined in M.G.L. c. 66A and 42 CFR 431, subpart F, and that in accepting such data it becomes a holder of Personal Data. Provider agrees that, in the performance of its services hereunder and in a manner consistent with the Privacy Rule, it shall comply with M.G.L. c. 66A and any other applicable state or federal law governing the privacy or security of any data received under the Agreement. Provider may only use and disclose Personal Data, and any data derived or extracted from such data, for the purpose of performing services under the Agreement, and may not disclose such data, and any data derived or extracted from such data, to any person or entity other than its authorized agents and subcontractors in the performance of its obligations under the Agreement, or, at the direction of MBHP, to the subject of the data. Provider shall inform each of its employees having any involvement with the Personal Data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

(c) Provider shall make reasonable efforts to ensure the physical security of, and to prevent the unauthorized use or disclosure of, PHI, Personal Data or other confidential information under its control, including but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use to input documents and output documents.

(d) Provider shall immediately report to MBHP, both verbally and in writing, any use or disclosure of PHI not provided for by this Exhibit D of which it becomes aware, together with any harmful effect of such violation of which it becomes aware. Provider shall also immediately report any instance where PHI or any other data obtained under the Agreement is requested, subpoenaed, or becomes the subject of a court or administrative order or other legal process. In

response to such requests, Provider shall take all necessary legal steps to comply with M.G.L. c. 66A, Medicaid regulations including 42 CFR §431.306(f), and any other applicable federal and state law. In no event shall Provider's immediate reporting obligations under this paragraph be delayed beyond two (2) business days from obtaining such knowledge or request for data.

(e) Provider shall take all appropriate legal action necessary to:

1. Cooperate with MBHP's efforts to mitigate any harmful effect known to Provider of a use of disclosure of PHI obtained under the Agreement by it in violation of the requirements of this Exhibit D;

2. Retrieve any PHI used or disclosed by it in a manner not provided for by this Exhibit D; and

3. Take such further action as may be required by any applicable state or federal law concerning the privacy and security of PHI obtained under the Agreement.

Provider shall report to MBHP the results of all mitigation actions taken by it under this provision. Upon MBHP's written request, Provider shall take such further actions as deemed appropriate by MBHP to mitigate, to the extent practicable, any harmful effect known to Provider of a use or disclosure of PHI by it in violation of the requirements of this Section 1.(e). Any actions to mitigate harmful effects of privacy violations undertaken by Provider on its own initiative or pursuant to MBHP's request under this provision shall not relieve Provider of its obligations to report privacy violations as set forth in other provisions of this Exhibit D.

(f) If Provider maintains a Designated Record Set on MBHP's behalf, Provider shall provide MBHP or, upon MBHP's request, the Members, with access to or copies of any PHI maintained by it, as shall be necessary for MBHP to meet its obligations under 45 CFR §164.524 to provide a Member with access to certain PHI pertaining to the Member. Such access or copies shall be provided to MBHP or to the Member at a reasonable time and manner to be specified by MBHP in the request and as shall be necessary for MBHP to meet all time and other requirements set forth in 45 CFR §164.524.

(g) If Provider maintains a Designated Record Set on MBHP's behalf, Provider shall make any amendment(s) to PHI that MBHP requests as shall be necessary for MBHP to meet its obligations under 45 CFR §164.526. Such amendments shall be made promptly in a manner specified in, and in accord with any time requirement under, 45 CFR §164.526.

(h) Provider shall document all disclosures of PHI, and required information related to such disclosures, as would be necessary for MBHP to respond to a request by a Member for an accounting of disclosures of PHI and related information in accord with 45 CFR §164.528. Within ten (10) business days of MBHP's request, Provider shall make a listing of such disclosures and related information available to MBHP, or upon MBHP's direction to the Member.

(i) Provider shall make its internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by it on behalf of MBHP available to the Commonwealth of Massachusetts Executive

Office of Health and Human Services ("EOHHS") or the U.S. Secretary of Health and Human Services, in a time and manner designated by either the Division or the Secretary.

Section 2. Permitted Uses and Disclosures by Provider. Except as otherwise limited in this Exhibit D, Provider may use or disclose PHI or Personal Data to perform its obligations under the Agreement, provided such use or disclosure would not violate the Privacy Rule if done by MBHP or not violate the minimum necessary policies and procedures of EOHHS.

Section 3. Termination for Violation of Exhibit D of the Agreement. (a) Notwithstanding any other provision in the Agreement, MBHP may terminate this Agreement immediately, upon written notice, if MBHP determines, in its sole discretion, that Provider has materially breached any of its obligations set forth in Exhibit D, or any other provision of the Agreement pertaining to the security and privacy of any PHI or any data provided to Provider under this Agreement.

(b) In the event that termination of this Agreement for a material breach of any obligation regarding PHI is not feasible, or if a cure is not feasible, MBHP shall report such breach or violation to EOHHS.

Section 4. Effect of Termination for Violation of Exhibit D. (a) Except as provided immediately below in subsection (b), upon termination of the Agreement for any reason whatsoever, Provider shall return or destroy all PHI and any other Personal Data obtained or created in any form under the Agreement, and Provider shall not retain any copies of such data in any form. This provision shall apply to all PHI and data in the possession of Provider's subcontractors or agents, and Provider shall ensure that all such data in the possession of its subcontractors or agents has been returned or destroyed and that no subcontractor or agent retains any copies of such data in any form. For purposes of this Section 4, PHI shall not include the clinical records maintained by such subcontractors or agents in the treatment of their patients.

(b) Notwithstanding any other provision concerning the term of this Agreement, all protections pertaining to any PHI or other data covered by the Agreement shall continue to apply until such time as all such data is returned to MBHP or destroyed.

Exhibit E

Minimum Wage Table for ESP Positions Comparable to DMH State Positions Providing ESP Services

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
ESP Director	Clinical Social Worker (D) Psychologist IV	Program Director (UFR Title 102)	$62,202.14
QM/ RM Director	Manager VI	Supervising Professional (UFR Title 104)	$52,399.08
Program Manager	Clinical Social Worker (D)	Program Function Manager (UFR Title 101)	$62,202.14
Clinical Supervisor	Clinical Social Worker (C) Human Services Coordinator (D)	Supervising Professional (UFR Title 104)	$52,399.08
Nursing Manager RN	Registered Nurse IV Registered Nurse V	N. Midwife, N.P., Psych N. , N.A., R.N. – MA (UFR Title 107)	$62,225.86
		R.N. – Non-Masters (UFR Title 108)	**$51,552.04**
Nursing RN	Registered Nurse II Community Psychiatric MH Nurse	R.N. – Non-Masters (UFR Title 108)	$51,552.04
Nursing LPN	Licensed Practical Nurse I Licensed Practical Nurse II	L.P.N. (UFR Title 109)	$40,513.20
Certified Peer Specialist	Mental Health Coordinator I	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS w/CPS preferred	Human Services Coord (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**

[1] "the lesser of step one of the grade or classification under which the comparable regular agency employee is paid, or the average private sector wage rate for said position as determined by the executive office for administration and finance…."

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
BS Milieu	Mental Health Worker I Mental Health Worker II	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu w/ CPS preferred	Human Services Coordinator (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
Paraprofessional (Family Partner)	Mental Health Coordinator I	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
MS Triage Clinician	Human Services Coordinator (C) Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
MS Clinicians	Human Services Coordinator (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinician Mobile	Human Services Coordinator (C) Clinical Social Worker (A/B) Clinical Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
Safety Staff	Mental Health Worker I	Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
Admin. Assistant	Administrative Assistant I Clerk III	Program Secretarial/ Clerical Staff (UFR Title 137)	**$27,543.92**

MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP

Emergency Services Program (ESP) Procurement for the 4 ESPs Currently Operated by the Massachusetts Department of Mental Health in the Southeast Region of the State, including Brockton, Cape Cod and the Islands, Fall River, and Taunton/Attleboro

Request for Responses

Issued
7/6/2015

EMERGENCY SERVICES PROGRAM PROCUREMENT

Table of Contents

LIST OF APPENDICES

I. Introduction

The Massachusetts Behavioral Health Partnership (MBHP) intends to secure a contract on behalf of MassHealth for the delivery and management of Emergency Services Programs (ESP) in the Southeast region catchment areas: Brockton, Cape Cod and the Islands, Fall River, and Taunton/Attleboro. These services are currently provided by the Department of Mental Health (DMH).

In accordance with the June 2012 Guidelines for Implementing the Commonwealth's Privatization Law as required under Chapter 296 of the Acts of 1993, this document lays out the necessary services which are currently covered under DMH's ESP program in the Southeast region. This document also outlines all expected performance measures via the program's detailed specifications as well as quality measures that will be used to measure the effectiveness of the program following its transition.

A. Mission Statement

The mission of the Emergency Services Program (ESP) is to deliver high quality, culturally competent, clinically and cost-effective, integrated community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, rehabilitation, and recovery.

B. Guiding Values

The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows an individual to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters the ESP provides a core service of crisis assessment, resolution-focused treatment intervention, and stabilization. These encounters must also include crisis behavioral health assessments and offer short-term crisis counseling that includes active listening and support.

The ESP provides solution-focused and strengths-oriented crisis intervention (i.e. active listening, support, brief counseling) aimed at working with the individual and his/her family and/or other natural supports to bring relief to the crisis state, reduce symptoms, improve functioning, reduce harm, promote understanding of the current crisis, resolve ambivalence, identify solutions, and collaborate on decisions to access resources and services for comfort, support, assistance, and treatment.

As agreed upon, and after engaging the individual (and parent/guardian when applicable) in an informed, shared decision-making process, ESP arranges the behavioral health services that the individual selects to further treat his/her behavioral health condition based on assessments completed, declared readiness and preference, and the individual's demonstrated medical need. The ESP coordinates with other involved service providers and/or newly referred providers to share information (with appropriate consent) and makes recommendations for a treatment plan. The ESP also provides the individual and his/her family with resources and referrals for additional or alternate services and supports, such as recovery-oriented and consumer-operated resources in their community.

While it is expected that all ESP encounters include the basic components outlined above, these services also require flexibility in the focus and duration of many additional tasks associated with initial interventions, an individual's participation in treatment, and the number and type of follow-up services. ESP services are directly accessible to individuals who seek behavioral health services on their own and by those who may be referred to the program. ESP services are preferably community-based in order to bring treatment to individuals in crisis, allow for consumer choice, and offer medically necessary services, in the least restrictive environment, that are most conducive to stabilization and recovery.

C. Program Goals

The goals of the Emergency Services Program (ESP) are as follows:

Treatment Level of care: Local ESPs will operate as a discrete treatment level of care that delivers comprehensive crisis behavioral health services, including but not limited to crisis assessments, resolution-focused interventions, and stabilization services including CCS for adults as well as community-based stabilization for youth for a period of up to 7 days. The expectancy is that effective ESP treatment services will increase coping and functioning, decrease risk and thus diminish the need for a more restrictive level of care. This includes the capacity and competency to address the needs of special populations, including children and families. ESP is NOT a screening service that is limited to assessing eligibility for various levels of care.

Transformative: ESPs are not only committed to achieving established outcomes but also to serving as a local driver in transforming the way behavioral health crisis services are accessed and delivered across the community. This includes leading, supporting and contributing to initiatives, forums and collaboratives that increase the capacity and competency of community partners (community treatment providers, hospitals, schools, state agencies, law enforcements, courts, homelessness and housing services, local governments and businesses) in preventing and supporting individuals in crisis, assuring care continuity before, during and after an episode of crisis.

Timely: ESPs will respond to all requests for crisis assessment, intervention, and stabilization in a timely fashion, as required in Appendix II: ESP Performance Specifications and Appendix III: Quality Indicators. These performance specifications are intended to be responsive to the individual or their caretaker's sense of urgency and to prevent adverse impacts which treatment delays may have on individuals and families. Timeliness must be achieved through effective staffing, geographic location and dispatch strategies and not compromise the delivery of a quality, complete treatment service for one person in order to begin in a timely fashion with the next person.

Community-based: ESPs will provide crisis behavioral health services in the community, through Mobile Crisis Intervention services for youth/families and adults, accessible community-based locations, and adult Community Crisis Stabilization (CCS). These programs will ensure that ESP services reach those individuals in need, allow for consumer choice, and

offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery.

Diversion: Through an array of initiatives and in ways that are experienced as beneficial to individuals in crisis, ESPs will shift utilization from more restrictive settings when that setting is not necessary, effective or desirable for the person in crisis, particularly hospital emergency departments (ED) and inpatient psychiatric care. ESPs will interrupt patterns of community over-reliance on hospital EDs to the extent permitted under applicable state and federal law. ESPs will focus on becoming the first point of contact in the event of a behavioral health crisis in an effort to shift volume away from hospital ED use. ESPs will also seek to maximize the use of community-based alternatives consistent with medical necessity criteria in lieu of admissions to inpatient psychiatric care. ESPs achieve this practice shift through effective engagement/collaboration and delivery of resolution-focused interventions that will lessen demand for higher levels of care, rather than by restricting access or imposing other plans.

Recovery-oriented: ESPs will support resiliency, rehabilitation, and recovery of all individuals by integrating mental health, substance use, and co-occurring recovery and rehabilitation principles and practices throughout the service delivery model to continually emphasize recover oriented care.

Clinical quality and consistency: ESPs will provide medically necessary and clinically appropriate behavioral health crisis assessment, intervention, and stabilization to all individuals they serve, consistent with their clinical presentation, culture, and special needs. This level of clinical care will be offered consistently across all ESPs statewide.

Cultural competence: ESPs will provide culturally and linguistically appropriate behavioral health services by ensuring that the content and process of the crisis assessment, intervention, and stabilization services are performed in culturally sensitive ways, recognizing among other things, an individual's preferred language and mode of communication.

Linkages: ESPs will be knowledgeable about community-based outpatient, diversionary, and inpatient mental health and substance use services, and will develop relationships with the providers of those services, ensuring effective consultation and referral processes and seamless transfer and coordination of care.

Information: MBHP will provide data to enable the local ESPs, MBHP, MassHealth, and DMH to manage the emergency behavioral health system effectively.

II. Statement of Services

The ESP provides crisis behavioral health services 24 hours per day, seven days per week, 365 days per year (24/7/365) to individuals who are experiencing a behavioral health crisis. The services provided by ESPs represent the hub of the behavioral health community safety net. The primary covered services included in the program are:

- Crisis screening (assessment)
- Short-term crisis counseling

- Crisis stabilization
- Medication evaluation

While this "core" set of ESP service is referred to throughout this document as "crisis assessment, intervention, and stabilization," this term should be considered as inclusive of all services listed above.

A. Program Service Scope

The scope of the ESP is defined in terms of the services that are provided as well as the populations served by the program. The following parameters define the scope relative to each of these variables.

1. Population scope

- *In scope*:
  - Age:
    - ESP services are available to individuals of all ages.
    - Adult CCS, operated by the ESP, is available to individuals 18 years of age and older.
  - Diagnosis
    - ESP services are available to individuals who present mental health, substance use, and/or co-occurring conditions.
    - Adult CCS is available for individuals with mental health or co-occurring conditions.
  - Payer
    - ESP services, including adult CCS services, are available to all uninsured individuals as well as those enrolled in, or covered by, the following public payers: MassHealth plans, including the PCC Plan (MBHP), the MassHealth-contracted MCEs, MassHealth fee-for-service; DMH only; Medicare; Medicare/Medicaid; One Care; and Care Plus.
- *Out of scope:*
  - Diagnosis
    - Adult CCS services will not be available to individuals if the sole/primary focus of the crisis intervention is a substance use condition.
  - Payer
    - Payment will not be provided to ESPs for ESP or adult CCS services for individuals with commercial insurance. This contract does not mandate ESPs to provide ESP and/or adult CCS services to this population, and any resulting contract with MBHP shall not require ESPs to provide ESP and/or adult CCS services to such populations. ESPs are encouraged to seek contracts with commercial payers for the provision of ESP and adult CCS services to their members.

2. Service scope

- *In scope:*
  - Community-based behavioral health services that provide a core service of behavioral health crisis assessment, intervention, and stabilization to all utilizers of ESP services, at all ESP locations and through all ESP services components, including but not limited to:

    - Mobile Crisis Intervention, for youth under age 21, as a component of the Children's Behavioral Health Initiative (CBHI)
    - Adult Mobile Crisis Intervention services.
  - Adult Community Crisis Stabilization (CCS) services for ages 18 and older.

B. Core Competencies

All ESP providers demonstrate the capability to meet the following competencies:

Crisis services

The fast-pace and unpredictable demand for 24/7/365 crisis services requires that selected ESP providers pay very close and ongoing attention to service flow and staffing patterns. Core competencies include.

- Ability to deliver services requiring crisis response on demand
- Success in meeting response requirements in a crisis environment and ability to comply with response-time requirements mandated in Appendix II: ESP Performance Specifications and in Appendix III: Quality Indicators.
- Success in managing resources to respond quickly to fluctuations in demand in a crisis environment (through use of strategies such as cross-training, use of on-call staffing, and non-traditional scheduling)
- Efficiency in the dispatching of individuals or teams, managing on-site crisis service and crisis stabilization capacity and referral processes
- Ability to hire, develop, and retain staff who are competent at mobile crisis response, are skilled at risk management, and are able to operate in an independent and self-directed fashion
- Use of electronic, telephonic, and other technological tools that optimize efficiency, reduce risk, and/or otherwise support achievement of results

Upstream intervention

As is the case with most healthcare interventions, early identification and treatment of symptoms can often prevent a full-blown crisis episode. Therefore all ESP programs must contain the following core competencies:

- A commitment to intervention at the earliest possible point in the crisis episode in a cost effective manner that contributes to the prevention of adverse outcomes, such as arrest, filing for an emergency petition, loss of housing, family stress, or injury to self or others
- Commitment to facilitating rapid access to a range of urgent treatment services
- Commitment to collaborating with other systems in managing behavioral health crises when risk of out-of-home placement is high

Recovery-oriented treatment

To achieve optimal results, it is essential that ESP providers move fully from a deficit/disability construct to one that is strengths-based and client-driven. In order to effectively accomplish this, ESP programs must deliver services in a manner that is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) consensus statement on mental health recovery, which is provided in Section F, Recovery-Oriented Services.

Cultural and linguistic competence

The Substance Abuse Mental Health Services Administration (SAMHSA) defines cultural competence as "an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations." The potential consequences of inadequate attention to and insufficient attainment of, cultural and linguistic competency are particularly great for ESPs given the high-risk nature of the work and relative lack of alternatives for seeking crisis intervention. Therefore all ESP providers must:

- Provide services in a culturally and linguistically competent manner, including access to informal and formal supports reflecting the family's cultural and linguistic preferences, including bilingual professionals, materials and interpreters.
- Hire, develop, and retain culturally and linguistically competent staff
- Commit to continuous learning in the area of cultural competence, reflected in training curricula, supervision, and performance evaluation at all levels of the organization
- Commit to continuous evaluation of the service environment, written materials, communications, facilities, and appearance of staff from a cross-cultural perspective in an effort to promote an open, welcoming, and accepting environment

Mobile (non-hospital) response: *the preferred service delivery model*

The preferred environment for the delivery of crisis services is in the home or other natural community setting, which is intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs), lessen the expectancy of and reduce the likelihood of use of restrictive dispositions such as psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner. Therefore ESP providers must:

- Be able to implement a service delivery model that achieves the provision of the majority of ESP services for adults and all MCI services for youth in the home or other natural community setting. (Crisis assessments for youth only occur in a hospital emergency department (ED) if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuses required consent for service in home or alternative community settings; or if request for Mobile Crisis Intervention originates from a hospital ED.)
- Support the development of procedures and decision-making tools that promote delivery of ESP services in the community and outline when use of ED/911 is indicated.
- Arrange for services to be alternatively delivered in the ESP's community based location or other setting consistent with consumer/family preferences, time of day, or clinical considerations.
- Tailor crisis behavioral health services in a home/community environment.

Least restrictive treatment

As is the case elsewhere in the nation, there is heavy statewide reliance on EDs as the providers of first contact in the event of a behavioral health crisis. Persons who receive behavioral health crisis services in the ED are more likely to be hospitalized than those treated in the community. While EDs are an important component of the crisis continuum, most behavioral health crises can be more effectively addressed in the community. Doing so adheres to the principle of least-

restrictive treatment, while ensuring the provision of medically necessary services, and will increase the likelihood of referral to appropriate, timely, and least-restrictive ongoing medically necessary services, consistent with individual and community safety as follow-up to the crisis service. Therefore all ESP providers must:

- Commit to care that is voluntary and consumer-directed and is delivered in, or as close to, home as possible
- Deliver care that is minimally disruptive
- Create a service pathway that screens for the need to refer up to, rather than step-down from, hospital-based emergency care

Effective use of treatment resources

Effective utilization management increases the likelihood that treatment options are available when needed. Without a broad continuum of services and resources, the likelihood increases that scarce resources will be misappropriated just to ensure that some service is provided. Community Crisis Stabilization services are beneficial only to the degree that there are regular openings, and that they remain true to their intended purpose. Programs that seek to grow and effectively utilize resources, such as reserved appointment slots for rapid urgent referrals (in or outside of own agency), broaden the continuum of resources that they can offer to the persons they serve, increase the likelihood of a discharge home, and increase consumer satisfaction. Because of the volume and variety of needs of those served, ESPs are well-positioned to identify persons in need of specialized services such as Enhanced Acute Treatment Services (E-ATS), Intensive Care Coordination (ICC), In-Home Therapy, or Program of Assertive Community Treatment (PACT), and should develop referral relationships and processes that will fast-track linkage. Therefore all ESP providers must have:

- A commitment to ensuring medically necessary services and the right level of care for the right length of time
- The ability to measure supply of services and demand for those services, and implement strategies, in collaboration with MBHP, to ensure access
- An assurance to efficient and timely discharges from the ESP's community-based location and CCS to maximize service capacity
- 24/7/365 ESP access to capacity information at CCS and other outpatient and diversionary levels of care
- 24/7/365 ESP linkage capability with CCS and other outpatient and diversionary levels of care

Intersystem knowledge, planning, and affiliation

While ESPs might be the most visible provider of crisis behavioral health services, a community is not well-served if ESPs bear the full burden of providing an effective safety net. The bulk of crisis work should be focused on prevention and very early identification of symptoms by those entities that are serving persons/families in an ongoing capacity. Cross-system education will increase competency in effective use of ESP services. For example, advances in mental health system collaboration with, and training of, law enforcement officers have led to very exciting programs and outcomes in this state and elsewhere. Therefore ESPs must

- Demonstrate broad knowledge of the community behavioral health system via:
  - Excellent collaborative skills – uses collateral information effectively

  - Knows what services are provided in the community, how they are funded, and how clients access them; develops professional relationships with peers in these agencies
  - Able to use system resources in order to complete work in an efficient fashion and to facilitate access to services by clients
- Knowledge of referral streams into the crisis system
- Identification and amelioration of barriers to early, upstream intervention
- Strategic initiatives to strengthen collaboration with key partners in crisis prevention, early intervention, hospital and jail diversion, and placement disruption. Partners include, but are not limited to:
  - Law enforcement entities
  - State agencies including child and elder protective services and juvenile justice
  - Schools
  - Residential treatment facilities
  - Hospitals
  - Primary care clinicians and health centers

Commitment to Continuous Quality Improvement

Though ESPs are the primary provider of community-based behavioral health crisis services, adopted strategic goals should reflect both agency-specific and systemic outcomes, indicators, and measures. The success of the ESP in meeting its service-specific and agency-specific goals, and contributing to the achievement of systemic outcomes in its communities, depends greatly on the degree to which the ESP has effectively engaged the broader system in supporting and strengthening the community crisis continuum and the service/referral pipelines both into and out of crisis services. ESP providers must therefore:

- Use continuous quality improvement processes, including outcomes measures and satisfaction surveys, to measure and improve quality of care and service delivered to persons served, including youth and their families, and services to special populations
- Routinely track overall and discipline-specific service volume and type by day and by shift so that staffing and service patterns are optimally efficient
- Routinely analyze trends in referral-in/referral-out patterns, and develop specific measures aimed at reducing overuse of hospital EDs
- Evaluate service penetration patterns by race, age, culture, geography, and other variables for indicators that services may not be viewed as being accessible
- Plan to impact and track strategic objectives to achieve or contribute to the achievement of:
  - Increased ED diversions
  - Reduced use of inpatient psychiatric treatment
  - Reduced commitments
  - Increased criminal justice diversion for youth and adults, to the extent resulting from the youth/adult's behavioral health condition
  - Increased diversion from out-of-home placement
  - Increased volume of risk management/safety plans and WRAP plans filed with ESP
  - Achievement of linkage timeframe targets in areas such as:
    - Urgent psychiatric appointments
    - ICC linkages
    - Admission to diversionary services, including CCS, CBAT, In-Home Therapy, EATS, and ATS

- Establish/strengthen affiliations and collaborations as measured by
  - Impact of partnership on achieving strategic objectives
  - Adoption of shared outcomes

C. Clinical Competencies

ESP providers must also possess significant clinical competencies in order to effectively deliver core and ancillary services which fall under the ESP program. All ESP Programs therefore must possess satisfactory levels of clinical competency in the following areas:

Clinical assessment

All ESPs must demonstrate an ability to perform a focused and comprehensive assessment of persons in crisis due to a mental health and/or substance use condition that includes:

- Understanding of the presenting problem as defined by the person in crisis, family, referral source, and/or other stakeholders
- Mental Status Exam, including assessment of previous and current risk of harm to self or others
- Assessment of current or past use of substances and indications for arranging immediate medical treatment or medical follow-up, including the capacity to screen for intoxication or withdrawal
- Assessment of other medical conditions and indications for immediate medical treatment and medical follow-up
- Multi-axial diagnosis (DSMV)
- Specific identification of biological, psychological, and all social domain stressors and strengths (that either increase or decrease risk)
- Multi-system involvement or needs (i.e., educational system, child/adult/elder protective services, juvenile justice, criminal justice, primary care, military/veteran, or homelessness services)
- Assessment of strengths, resources, capacities, past successes, and natural supports
- Level-of-care assessment

ESPs should also have a developed protocol for multi-disciplinary evaluations, based on the comprehensive assessment of multiple contexts including:

- Comprehension of normal child, adolescent, and adult development
- Comprehension of grief and trauma

Diagnostic accuracy

- Comprehension of, and ability to use, the Diagnostic and Statistical Manual
- Knowledge of diagnostic, medical, substance-related, developmental, and environmental differentials that must be considered
- Awareness of the differences in manifestation of mental health and substance use conditions in children versus adolescents, versus adults

Member engagement and de-escalation skills

- Able to engage Member in a manner that is both professional and calming
- Able to identify cues that might indicate the best means of communicating with the client

- Able to identify, consider, and respect cultural/lifestyle differences and the impact on treatment
- Able to work with Members in their natural environment
- Ability to modify engagement techniques to meet the individualized needs of the Member
- Skilled in verbal and non-verbal de-escalation techniques

Risk assessment and management skills

ESP services are widely accessible, and persons seek these services due to crises that are self-defined. Clinical presentation varies dramatically as it relates to the apparent significance and impact of stressors; the coping ability of the person/family in crisis; the nature and degree of risk; the co-morbid presence of a medical condition or disability; the degree to which care is being sought voluntarily; the age, culture, and life experience of the recipient and family; and the concurrent involvement in other systems. Competent crisis providers are in every way respectful of the perspective of the service recipient, family, and other stakeholders in assessing risk and identifying resources and solutions. Crisis assessments, though focused in nature, must address a broad array of risks, including those present in the daily living environment. Therefore ESP providers must:

- Establish a culture that "risk management is everybody's job"
- Be able to identify potential risks to client or others, and to develop and implement a plan of action to reduce those risks
- Recognize lethality risk in special populations
- Use problem-solving skills by considering various options and potential outcomes in a creative yet timely manner
- Identify the need for, seeks, and utilizes supervision/consultation
- Seek consensus-driven dispositions

Recovery-promoting treatment approach

Recovery-promoting treatment approaches are those that instill hope; capitalize upon the strengths of the person and his or her family/support system; are self-directed; are aimed at enhancing problem-solving, coping, and other competencies; and are highly individualized and collaborative. Recovery-oriented processes recognize and respect that change occurs in nonlinear stages, and effective providers assess the level of change-readiness and pair stage-effective intervention techniques accordingly. Therefore ESP providers must:

- Use interventions that are compatible with rehabilitation and recovery principles and likely to promote self-help, including techniques found in:
    - Developing authentic relationships
    - Risk management that includes dignity of risk concepts
    - Collaboration in assessment and disposition planning
    - Wraparound care planning
    - Solution-Focused Therapy
    - Cognitive Behavioral Therapies
    - Stages of Change
    - Motivational Interviewing
    - Shared Decision-Making
    - Illness Management and Recovery
    - Peer-to-Peer Support

- Refer to recovery-oriented programs, including peer-led services
- Preserve the right to refuse treatment when at all possible.
- Strive to achieve a consensus disposition.

Capacity and competency to treat special populations

Unique competencies are required to assess and intervene with these and other special populations. Well-developed policies and procedures, combined with effective training and supervision and appropriate referral pathways for special populations will improve treatment outcomes, increase individual satisfaction, and decrease risk. Therefore ESP providers must be capable of providing services to these special populations:

- Children, adolescents, and families
- Adults
- Elders
- Veterans
- Culturally and linguistically diverse populations
- Persons with mental health condition
- Persons with substance use conditions
- Persons with co-occurring mental health and substance use conditions
- Persons with intellectual and developmental disabilities
- Persons who are deaf or hard of hearing
- Persons who are blind, deaf-blind, and visually impaired
- Persons who are homeless
- Persons who are gay, lesbian, bisexual, transgendered

D. Mobile Crisis Intervention

In order to qualify to provide the Mobile Crisis Intervention component of ESP services, ESP services need to demonstrate compliance with the core competencies articulated above for all aspects of ESP service delivery, as they apply to providing crisis behavioral health services to youth and their families, particularly the following:

- Comprehension of grief and trauma in children and adolescents
- Diagnostic accuracy in the assessment of children and adolescents
- Awareness of the differences in manifestation of mental health and substance use conditions in children versus adolescents, versus adults
- Risk assessment and management skills in working with children, adolescents, and families
- Client engagement and de-escalation skills with children, adolescents, and their families
- Competency in crisis theory and in the use of interventions with children, adolescents, and families that are compatible with principles or resiliency and recovery and likely to stimulate self-help including techniques utilized in:
    - Solution-Focused Therapy
    - Cognitive Behavioral Therapy
    - Stages of Change
    - Motivational Interviewing
    - Shared Decision-making
- Demonstrated broad knowledge of the community behavioral health system for children, adolescents, and families including Child Behavioral Health Initiative (CBHI) services.

- Demonstrate strategic initiatives to strengthen collaboration with local CBHI providers.
- Coordinate all behavioral health crisis response with the youth's existing providers, including Intensive Care Coordination (ICC), In-Home Therapy (IHT) and outpatient providers, other care management programs and primary care provider (PCP/PCC).

Additionally, with regards to providing Mobile Crisis Intervention component of ESP services, ESP programs need to demonstrate the ability to adhere to and demonstrate the following core competencies:

Agency/programmatic competencies

- Documented understanding of Crisis Theory, Recovery-Oriented Care, Wraparound planning process, and Systems of Care principles and philosophy at all levels of the organization's management, and preferably experience in the implementation of these approaches
- Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels, in providing behavioral health services to children, adolescents, and their families
- Documented experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis intervention, and/or treatment services; administrative infrastructure that supports the delivery of Mobile Crisis Intervention 24/7/365, including access to consultation with a child-trained supervisor and board-certified or eligible psychiatrist
- Ability to integrate youth and family voice in organization governance
- Solicits and values the youth's view of the crisis situation and possible solutions
- Competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services
- Articulation and adherence to a program philosophy that:
    - Values a young person's return to natural environment
    - Expects Member's return to higher level of functioning
    - Instills Member/family with hope for the future
    - Expects improvement by the end of intervention
- Outcomes data, quality improvement processes, and satisfaction survey instruments and results from the ESP that are specifically focused on services for youth and families
- Relationships with child- and family-focused community resources in the service area, including but not limited to, child-serving state agencies and social service providers, schools, residential programs, family and youth organizations, pediatric primary care providers, and ability to coordinate care and treatment across providers and service agencies
- Membership in child advocacy and/or child-focused trade organizations

Clinical competencies

- Comprehension of family dynamics and ability to engage caregivers as partners in finding solutions
- Comprehension of normal child development

  - Developmental milestones
  - Cognitive development
  - Identity development
  - Physical development
- Adherence to Wraparound philosophies[1]
  - Family voice and choice
  - Team-based (includes child and family)
  - Use of natural supports
  - Collaboration
  - Community-based
  - Culturally competent
  - Individualized
  - Strengths-based
  - Persistence
  - Outcomes-based

Successful bidders are expected to demonstrate a commitment to best practice principles as outline in the documents below:

- MCI Practice Guidelines are located at

  http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/cbhi-resources-for-providers.html

- Crisis planning tool companion guide is located at

  http://www.masspartnership.com/pdf/Crisis-Planning-Tools_Guide_for_ProvidersFinal.pdf

III. ESP Structure

The structure of the Emergency Services Program system includes locally based ESPs supported by statewide functions that contribute to programmatic improvements and system efficiencies.

A. Local ESP Structure

Each locally based ESP shall be a comprehensive, integrated program of crisis behavioral health services, including services delivered through the ESP's mobile crisis intervention services for adults and children, in the ESP's accessible community-based location, and in the ESP's adult Community Crisis Stabilization (CCS) program. Each of these service components are described further in the section below. The selected ESP providers shall be expected to envision their programs, inclusive of all these service components, as one integrated emergency services program. They shall be expected to use their staffing resources in an integrated and flexible manner, using all available resources to respond to the needs of individuals who require their services on a daily basis, with fluctuations in volume, location of services, etc. The ESP structure

[1] Source: Eric J. Bruns, Janet S. Walker, Jane Adams, Pat Miles, Trina Osher, Jim Rast, and John VanDenBerg, (2004). *The Ten Principles of Wraparound*

includes staffing infrastructure to provide ESP specific management, clinical supervision, and direct services in proportion to the anticipated volume beginning in FY16 for each catchment area.

It is also expected that ESP programs shall have resources to support the management and delivery of ESP services, such as administrative and financial oversight, medical leadership, and technology infrastructure. Please reference Appendix IV for an example staffing pattern for an average size ESP.
Appendix II: ESP Performance Specifications.

B. Catchment Areas

Appendix I: ESP Catchment Areas lists the cities and towns to be included in each of the four Southeast ESP catchment areas as of July 1, 2015. A total of five local ESPs shall deliver ESP services in the Southeast region of the Commonwealth. Four of the five ESPs (formerly DMH operated) are included in this RFR and listed in Appendix I. One local ESP shall cover each of 4 catchment areas that were formerly DMH operated (The fifth ESP is already managed by MBHP and not included in the RFP). An entity may provide ESP services in more than one of the catchment areas, providing that all requirements are discretely met for each distinct catchment area.

C. System Level Structure

1. Contract management

MBHP is responsible for contract management, financial management, as well as the consistency and quality of ESP services. MBHP is responsible for claims payment for MBHP and uninsured consumers. Integral to ensuring consistency and quality of care, MBHP works with providers to develop statewide universal competencies for all ESP programs and ESP clinicians, which are to be integrated into the ongoing evaluation of each ESP.

Performance measurement

MBHP measures the performance of ESP contracts through a variety of quantitative and qualitative indicators. In collaboration with the Department of Mental Health (DMH) and MassHealth Office of Behavioral Health, MBHP has established Quality Indicators to measure the ESP provider requirements delineated in the General Performance Specifications, the ESP Performance Specifications, the Mobile Crisis Intervention Performance Specifications, and the Adult Community Crisis Stabilization Performance Specifications, all of which are included in the Appendices to this document. Please reference Appendix II for ESP Performance Specifications and Appendix III for a breakdown of ESP/MCI Quality Indicators.

The **Quality Indicators** include:

- Intervention Location
- Disposition
- Response Time in Minutes
- Response Time Percent within 60 minutes

Additional quality measures may include but are not limited to:

- Delivery of a comprehensive crisis service that minimally includes crisis assessment, intervention, and stabilization
- Clinical appropriateness of disposition, including use of diversionary services when clinically indicated
- Compliance with standards of care
- Satisfaction survey data
- Identifying and implementing quality improvement initiatives

MBHP will monitor and manage the performance of ESP services across all ESPs utilizing data on the following levels: provider, regional, and statewide. MBHP will monitor and manage the performance of each ESP through regular reporting requirements and in-person network management meetings.

ESPs shall be expected to comply with all reporting requirements of MBHP, as well as those of MassHealth.

Accountability to MassHealth-contracted Managed Care Entities (MCEs)

It is important to note that ESPs will also be accountable to other payers with whom they contract, including the MassHealth MCEs. This accountability will include, but not be limited to, the clinical care of their members, compliance with authorization procedures, and all other applicable requirements of the MCE, including information reporting requirements.

2. Statewide function

The local ESPs are further supported by the following statewide function. The ESPs are expected to use this resource in their daily service to individuals and families statewide, as required in

- *Massachusetts Behavioral Health Access (MABHA) website:* ESPs shall use MABHA to enable ESP clinicians to locate potential openings in mental health and substance use services for the purpose of referring individuals to those available services.
- The ESP is required to update the MABHA website a minimum of once per 8 hour shift, every day with current Community Crisis Stabilization bed availability.

3. Staff Compensation

For each position in which a private contractor will employ any person where the duties of the position are substantially similar to the duties currently performed by a regular DMH employee, the private contractor must pay at least a minimum wage rate as determined by the state pursuant to M.G.L. c. 7 §54(2). The minimum wage rates associated with ESP Core Staffing positions that are substantially similar to duties currently performed by DMH employees are summarized in Appendix V.

D. Program Model Overview

1. Emergency Services Program (ESP)

Description

MBHP will contract with one locally based provider to administer the ESP for each catchment area. The ESP is expected to contract with all MassHealth Managed Care Entities (MCE's).

Each ESP shall be a comprehensive, integrated program of crisis behavioral health services, including services delivered in the community through the ESP's mobile crisis intervention services for adults and youth, in the ESP's accessible community-based location, and in the ESP's adult CCS. The ESP shall provide crisis behavioral health services including but not limited to, the core clinical services of a behavioral health crisis assessment, intervention, and stabilization to all individuals, within the defined population scope, who access ESP services through any and all of these service components. Each of these service components are described below. The consistent availability of these service components across all ESPs statewide is necessary in order to ensure consistency in the type and quality of these services in all catchment areas and to serve as the basis for educating the public about the availability of these services and facilitating access to them.

Local variation

While every ESP across the Commonwealth shall offer all of these service components, there will be some variation among ESPs, so as to be responsive to differences in local needs and resources. For example, while access to crisis behavioral health services shall be provided on a 24/7/365 basis in all catchment areas through one or more service components, the operating hours of the ESPs' community-based locations may vary, in part as dictated by volume in a particular catchment area. Additionally, the ESPs' responses to the needs of special populations may vary, based on local population characteristics and related community resources. Finally, there may be variance in the service components that the ESP provider will operate directly and those that the ESP provider may subcontract to another provider.

Access

All ESP services in a given catchment area shall be accessed through a toll free number operated by the contracted ESP provider 24/7/365. The ESP shall triage calls to its most appropriate ESP service component, the one that shall provide crisis behavioral health services to the individual in the least restrictive setting, ensuring safety and responsiveness to consumer and family choice.

Integration

ESP providers shall be expected to envision and manage their programs, inclusive of all service components, as one integrated emergency services program responsible for meeting the crisis behavioral health needs of the populations identified in this document, throughout their catchment areas, 24 hours per day, 7 days per week, 365 days per year. The overall ESP program should operate in a fashion that ensures fluidity among its service components and minimizes transitions and inconvenience to individuals in crisis. With the use of flexible, cross-trained staff and cross-scheduling, programs should demonstrate the ability to respond to varying levels of demand in ESP site-based crisis intervention services, mobile crisis intervention services, and CCS services.

It is important to note that the ESP's adult CCS shall be required to be co-located with the ESP community-based location, preferably upon initiation of the ESP contract, or within three months. Co-locating ESP services with other services that may be helpful to individuals who utilize ESP services, such as outpatient and diversionary services, operated by their organizations and/or other provider agencies is also encouraged, but not mandatory.

Management functions

The contracted ESP provider shall conduct all clinical, medical, quality, administrative, and financial oversight functions across all the services provided by the ESP and all locations in which these services are provided, including any ESP services provided by subcontractors. More specifically, management functions shall include:

- Staff recruitment, hiring, training, supervision, and evaluation
- Triage
- Clinical and medical oversight
- Quality management/risk management
- Information technology, data management, and reporting
- Claims and encounter form submission
- Oversight of subcontracts
- Interface with payers including the MassHealth-contracted Managed Care Entities (MCEs)
- Interface with MBHP for contract management purposes
- Member and Stakeholder Satisfaction Surveys

Safety

Safety is integral to all ESP services, functions, and operations. Assessing and mitigating risk for individuals who participate in ESP services, as well as for staff who provide them, is a priority. In fact, safety in the workplace is both a need and responsibility of employers in any profession or work setting, for their employees, their customers, visitors, and others who enter that workplace. The ESP model includes various resources and strategies toward this end. Offering various venues for services is one tool, as well as acknowledging that some individuals will continue to require the medical services of a hospital ED setting. Technology resources, including cell phones with GPS and laptops, have been included as operating expenses in the ESP rates. Staffing infrastructure, including bachelor's level staff, Certified Peer Specialists, and Family Partners have been included in the staffing pattern to provide support and comfort to consumers and families, as well as to be available to provide a two-person response, along with a master's level clinician, to many requests for mobile crisis intervention services. Additionally, specific "safety" staffing has been included in the staffing pattern for the ESP community-based locations, to be utilized by ESPs in a manner that helps to promote a calm and safe environment, mitigate risk, and facilitate safety in these settings. ESPs may choose to use these positions in a variety of ways that contributes to a safe environment. In part, this staffing will enable providers to ensure that at least two staff members are present in their community-based locations during at least high-volume operating hours. Finally, various training for all staff will be important to mitigating and managing risk, and sound triage protocols are important in enabling ESPs to make clinical decisions about the services each individual needs, the venue in which they are provided, and the staffing that can best provide them in both a clinically appropriate and safe manner.

Staffing

The ESP structure includes staffing infrastructure to provide ESP-specific management, clinical supervision, and direct services beginning in FY16 for each catchment area. ESPs shall be expected to use their staffing resources in an integrated and flexible manner, utilizing all available resources to respond to the needs of individuals who require their services on a daily

basis, while accommodating the specific needs of individuals and families, fluctuations in volume, location of services, etc.

It is also expected that bidders shall have resources to bring to bear on the management and delivery of ESP services, such as administrative and financial oversight, medical leadership, and technology infrastructure, and support for such overhead and has been included in the rate. Staffing of each Emergency Services Program shall include the following positions. Listed below are those positions that have management responsibility across all ESP service components and/or those that represent staffing in two or more of those components. Positions that are specific to one service component will be described in the section of this document related to that given service component.

- *ESP Medical Director***:** This is a psychiatrist who meets MBHP's credentialing criteria and is responsible for clinical and medical oversight and quality of care across all ESP service components. It is expected that the ESP provider agency will appoint one of the psychiatrists, who is in the staffing pattern for the ESP and/or CCS and works directly in one or both of those service components on at least a part-time basis, as the ESP Medical Director. This individual coordinates the functions of his/her ESP medical director role, the psychiatric care delivered by him/herself and/or other psychiatric clinicians during business hours, and the after-hours psychiatric consultation function fulfilled by him/herself and/or other psychiatric clinicians. Included is the responsibility for supervising all psychiatric clinicians performing psychiatric functions in any of the ESP service components. The ESP Medical Director is responsible for developing and maintaining relationships with medical providers and other stakeholders in the catchment area, including medical directors at local outpatient, diversionary, and inpatient services programs, hospital emergency department (ED) physicians, and primary care clinicians. This individual is available for clinical consultation to ESP staff members and community partners, including negotiating issues related to medical clearance and inpatient admissions.

- *ESP Director*: The ESP Director is a full-time position. This master's- or doctoral-level, licensed behavioral health clinician shares responsibility with the ESP Medical Director for the clinical oversight and quality of care across all ESP service components. He/she is also responsible for the administrative and financial oversight of the ESP contract, along with administrative and financial leadership of the contracted ESP provider agency. The ESP Director is the primary point of accountability to MBHP for the ESP contract and is responsible for all subcontracts and interface with public payers. The ESP Director ensures compliance with all requirements set forth by MBHP, including standard clinical assessment tools, electronic encounter forms, and other data collection mechanisms. The ESP Director is responsible for ensuring the provision of the core ESP services of crisis assessment, intervention, and stabilization to Members of all ages in all ESP service components and locations, including both mobile crisis intervention services and those provided on-site in the ESP's community-based location. He/she is responsible for staff recruitment, orientation, training, and supervision. He/she provides administrative and clinical supervision to key program-level supervisory staff. The ESP Director also

develops and maintains working relationships with all appropriate community stakeholders.

- *Quality Management/ Risk Management Director*: This master's- or doctoral-level staff person has a behavioral health background and is responsible for developing and implementing the quality and risk management program across all ESP service components. The Quality Management/Risk Management Director is responsible for all MBHP reporting requirements and for utilizing data reporting to track and trend quality indicators, ensure compliance with standards of care, and implement quality improvement initiatives. This individual is responsible for managing, resolving, and reporting all adverse incidents, complaints, and grievances. The Quality Management/Risk Management Director advises clinical staff on risk assessment, crisis prevention/safety planning, and risk management. This individual is responsible for implementing and utilizing all assessment and/or outcomes tools as required by the ESP contract with MBHP and implementing stakeholder satisfaction surveys.

- *Clinical Supervisor*: These licensed, master's- or doctoral-level behavioral health clinicians provide clinical supervision to all direct service staff across the ESP service components. Clinical supervisors of clinicians providing ESP services to children and adolescents must be child-trained clinicians.

- *Triage Clinicians*: These master's- or doctoral-level behavioral health clinicians answer all incoming phone calls and are responsible for triaging calls to the appropriate ESP service component, or to another appropriate resource, including 911 in acute emergencies. Bachelor's-level staff may answer triage calls with master's-level clinicians and supervisors available to consult with and take calls when indicated. Triage clinicians provide general information to callers, serving as a resource by assisting them in accessing care throughout the behavioral health system. Triage clinicians facilitate access to diversionary services, including setting up urgent psychopharmacology appointments, etc.

- *Clinicians*: These master's- or doctoral-level behavioral health clinicians provide crisis assessment, intervention, and stabilization services across all service components. Clinicians providing ESP services to children and adolescents must be child-trained clinicians.

- *Psychiatry:* These MDs and psychiatric nurse mental health clinical specialists (PNMHCS) who meet MBHP's credentialing criteria provide consultation across all ESP service components.

- *Psychiatric Consultation (after hours):* These psychiatrists and/or PNMHCSs who meet MBHP's credentialing criteria provide access to child and adult psychiatry consultation outside regular business hours. This consultation is provided to ESP staff members and others involved in the assessment, treatment, and/or disposition planning for Members.

The core ESP services of crisis assessment, intervention, and stabilization shall be provided in the ESP community-based location by master's level behavioral health clinicians, whose work shall be enhanced by the presence of the staff outlined below.

- *Certified Peer Specialists (CPSs)* help to make community-based ESP services welcoming, comfortable, supportive, and responsive to Members who utilize them and their families. Certified Peer Specialists provide support to the Member, update them on the ESP process as it unfolds, and offer such concrete assistance as food and drink. CPS staff convey hope and provide psycho-education, including information about recovery, wellness, and crisis self-management. They have in-depth knowledge of the particular catchment area served by the ESP and facilitate access to specific community-based resources, including recovery-oriented and consumer-operated programs. Certified Peer Specialists assist in arranging the services to which the Member is being referred after the ESP intervention, and they work with the Member and family to support them during the transition to those follow-up services. CPS staff also provide similar services in the ESP's adult mobile crisis intervention service and CCS, as staffing and time permit. The ESP is required to employ one FTE or more Certified Peer Specialists to work in the ESP's community-based locations.

- *Bachelor's-level staff* supports the master's-level clinicians in providing ESP services to Members, particularly during adult mobile crisis intervention services, as well as in the community- based location. These staff members help to support the Member and his/her family, and they perform such tasks as assisting with implementing the disposition determined by the master's-level clinician. This additional support brings efficiency to the system by allowing adult mobile response master's-level clinicians to focus exclusively on the provision of direct clinical services. ESP providers are encouraged to hire bachelor's-level staff who are also credentialed as Certified Peer Specialists.

- *Family Partner or Bachelor's Level Clinician (paraprofessional staff)* primarily attend to the experience of parents and caregivers as they navigate the crisis services process and support/make decisions for their children. Although the primary focus of the Bachelor's Level Staff person during an MCI intervention is attending to the experience of the parent/caregiver, the use of the title "Family Partner" is reserved for a person with lived experience as parent/caregiver of a child with a behavioral health condition and who uses that experience to inform their intervention and support. This specific attention to the experience of parents within the MCI service is stabilizing and can be change-activating. When parents/caregivers are activated to take a lead in their child's care, there is more effective use of and adherence to any subsequent treatment or safety plans. Family Partners purposefully use and share their lived experience when it is useful to a parent/guardian of a child in crisis. It can be incredibly helpful for some parents/caregivers, as it is rare to talk to someone else who has lived it. This type of peer to peer support is an innovation in the behavioral health crisis field and is supportive, stabilizing, empowering and change-activating.

- *"Safety" staff positions* in the ESP community-based location serve as a flexible resource to support ESPs in maintaining a calm and safe environment, mitigating risk, and

allowing services to be delivered safely in a community-based setting. ESPs may choose to use these positions in a variety of ways that contribute to a safe environment. In part, this staffing will enable providers to ensure that a minimum of two people are present in the ESP's community- based location during at least high-volume operating hours, or during low-volume hours when fewer clinical staff are working.

2. ESP Community-based Location

Description

The ESP's community-based location is the 24/7/365 "hub" of the emergency services program in each catchment area. The primary purposes of the ESP's community-based location are to:

- Coordinate the operation of, and access to, all the service components of the ESP
- Directly deliver its core service of crisis assessment, intervention, and stabilization at the ESP
- Provide a Community-based location as an alternative to hospital emergency departments (EDs) for individuals seeking behavioral health services when use of the ED may be avoided, such as when there is not a physical condition requiring medical assessment and intervention.

ESPs with contracts in more than one catchment area, might realize operational efficiencies such as centralized call/triage centers, training tools etc.

The ESP community-based location is thereby a primary venue, in addition to mobile crisis intervention services, through which the ESP provides community-based access to crisis behavioral health services. Ensuring that every ESP has a robust community-based location for these stated purposes represents a significant system enhancement. ESPs must have protocols to guide the decision making process regarding the location of intervention.

Expected outcomes from the ESP community-based location include the diversion of unnecessary volume from hospital EDs and increased consumer, family, and community satisfaction with access to crisis services in this less restrictive, community-based setting. ESPs encourage early crisis intervention in order to prevent the development of symptoms that may require hospital-based interventions. The ESP community-based location shall provide a setting that is more conducive than a busy hospital ED to the ESPs utilizing their focused expertise, rapid service initiation, skill in crisis intervention, knowledge of community resources, ability to access ongoing treatment and offer brief follow-up treatment, and ability to offer flexibility in service duration. ESPs offer a front door into crisis services with the opportunity to be referred up to hospital-based care when indicated.

The ESP shall perform the following functions at, or dispatched from, their community-based location. Any variance will need to be justified by the provider based on local needs and resources.

- Operate a toll free number on a 24/7/365 basis that shall:
  - Triage all requests for crisis services
  - Dispatch adult and Mobile Crisis Intervention services and maintain communication with individuals, families, and such other referral sources as hospital EDs to keep them informed of the expected arrival time of these services

- Access MABHA when seeking available resources for CBHI or 24 hour levels of care.
- Provide ESP services on-site at the community-based location for a minimum of 12 hours per day on weekdays and eight (8) hours per day on weekends. Recommended minimum hours are 7 a.m. to 11 p.m. weekdays and 11 a.m. to 7 p.m. weekends. (Note that ESPs shall operate Child and Adult Mobile Crisis Intervention services and the adult CCS 24/7/365, with the latter being co-located with the ESP community-based location at the initiation of the ESP contract or within three months thereof.)

The ESP community-based location shall offer an environment that encourages individuals and families to seek crisis services in this less restrictive, community-based setting. The physical environment and interpersonal climate shall be one that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support. Concurrently, the environment needs to communicate that this is a setting to receive help for crisis behavioral health needs rather than for routine services or general support and socialization.

The ESP provider must directly operate the ESP's community-based location. The ESP's community-based location must be an easy-to-find, centrally located physical site in a population center within the catchment area in which the provider is bidding. The site must be accessible to persons relying on public transportation.

Also included in the ESP program model and rates are some operating expenses that will facilitate successful delivery of clinical services at the community-based location and support consumers' ability to remain in the community while receiving medically necessary services. As reported by numerous stakeholders, it is often seemingly small details such as food and transportation that can make the difference in the attempt to support consumers through the ESP process and enable them to remain in the community. Modest levels of operating expenses that have been built into the ESP rates include food that will allow the ESP to provide comfort and nourishment to consumers and family members while receiving services; pharmacy, given that ESPs are often faced with needing to spend a small amount of money on a pharmacy co-pay to help a consumer obtain his/her medication and successfully participate in a community-based level of care; and transportation for situations in which the ESP may need to facilitate transportation for a consumer to a pharmacy to obtain medications or to a community- based disposition, such as an outpatient appointment. Thus, these operating expenses are meant to facilitate access to care and increase the feasibility of diversions and community-based services.

Concurrently, ESPs shall be expected to access other resources available to them and the individuals they serve, such as assisting them to arrange MassHealth transportation benefits, to provide or pay for these resources whenever possible.

3. Adult Mobile Crisis Intervention

Description

The Emergency Services Program (ESP) provides crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year (24/7/365) to Members of all ages who are experiencing a behavioral health crisis. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows a Member to

receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with a Member in crisis, the ESP provides a core service including crisis assessment, intervention, and stabilization. In doing so, the ESP conducts a crisis behavioral health assessment and offers short-term crisis counseling that includes active listening and support. The ESP provides solution-focused and strengths-oriented crisis intervention aimed at working with the Member and his/her family and/or other natural supports to understand the current crisis, identify solutions, and access resources and services for comfort, support, assistance, and treatment. The ESP arranges the behavioral health services that the Member selects to further treat his/her behavioral health condition based on the assessment completed and the Member's demonstrated medical need. The ESP coordinates with other involved service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. The ESP also provides the Member and his/her family with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community. While it is expected that all ESP encounters minimally include the three basic components of crisis assessment, intervention, and stabilization, crisis services require flexibility in the focus and duration of the initial intervention, the Member's participation in the treatment, and the number and type of follow-up services.

ESP services are directly accessible to Members who seek behavioral health services on their own and/or who may be referred by any other individual or resource, such as family members, guardians, community-based agencies, service providers, primary care physicians, residential programs, schools, state agency personnel, law enforcement, courts, etc. ESP services are community-based in order to bring treatment to Members in crisis, allow for Member choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery. Local ESPs provide crisis behavioral health services in the community, through mobile crisis intervention services, accessible community-based locations, and Community Crisis Stabilization (CCS) programs.

All ESPs shall provide Adult Mobile Crisis Intervention services to any community-based location, including private homes, from 7 a.m. to 8 p.m. Outside of those hours, Adult Mobile Crisis Intervention services shall be provided in residential programs and hospital EDs. ESP performance will be measured against established targets for the percentage of services that are provided on a "mobile" basis, exclusive of hospital EDs.

4. Adult Community Crisis Stabilization (CCS)

Description

The adult (ages 18 and over) Community Crisis Stabilization (CCS) program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18-20 under the Children's Behavioral Health Initiative (CBHI). CCS provides a distinct level of care where primary objectives of active multi-disciplinary treatment include: restoration of functioning; strengthening the resources and capacities of the Member, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized crisis prevention plan and/or

safety plan, as part of the Crisis Planning Tools for youth; and linkage to ongoing, medically necessary treatment and support services. CCS staff provides continuous observation of, and support to, Members with mental health or co-occurring mental health/substance use disorder conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care include: crisis stabilization; initial and continuing bio-psychosocial assessment; care coordination; psychiatric evaluation and medication management; peer support and/or other recovery-oriented services; and mobilization of family and natural supports and community resources. CCS services are short-term, providing observation and supervision, and continual re-evaluation.

CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery. CCS staff provides psycho-education, including information about recovery, wellness, crisis self-management, and how to access wellness and recovery services available in the Member's specific community. Guided by the treatment preferences of the Member, CCS staff actively involves family and other natural supports at a frequency based on Member needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. For young adults who are involved with, or who are referred for, CBHI services – including Intensive Care Coordination (ICC) – with Member consent CCS staff provide treatment recommendations and participates in team meetings, as appropriate.
CCS shall be primarily used as a diversion from an inpatient level of care; however, the service may be used secondarily as a transition from inpatient services, if there is enough service capacity and the admission criteria are met. Admissions to the CCS shall occur 24/7/365 based on determinations made by mobile and site-based ESP staff. Discharges from the CCS shall occur 24/7/365, and discharge processes shall include efficiencies that maximize service capacity. Readiness for discharge shall be minimally evaluated on a daily basis, and the length of stay is expected to be very brief.

Minimum Capacity

The allocations of CCS capacity identified in Appendix I: ESP Catchment Areas should be considered a minimum number that can be adequately supported by the core staffing pattern reflected and described under "staffing" below. Each catchment area must have a minimum number of CCS beds available as follows:

Brockton – 6
Cape and Islands – 6
Fall River – 5
Taunton/Attleboro – 7

Adult CCS program utilization will be monitored by MBHP to ensure adherence to the performance specifications for this service (Appendix II), the goals of the ESP system, and relevant performance indicators including by not limited to daily reporting of CCS capacity on Massachusetts Behavioral Health Access (MABHA) website at least once per shift, (3x daily) every day.

Location of adult CCS

The ESP's adult CCS is required to be co-located with the ESP community-based location, preferably upon initiation of the ESP contract, or within the first three months thereof. If a bidder is awarded a contract with this contingency and fails to meet the full set of criteria within three months, the provider may be at risk of termination of the contract.

Collaboration between ESP and adult CCS

The co-location of the adult CCS and the ESP's community-based location shall enhance service continuity and increase administrative efficiency to benefit those served. The overall ESP program shall operate in a fashion that ensures fluidity among ESP mobile services, site-based crisis services at the ESP community-based location and the CCS and minimizes inconvenience to individuals in crisis. With the use of fluidly trained staff and cross-scheduling, ESPs shall demonstrate the ability to respond to varying levels of demand in these three service components. All staff members are expected to share expertise in terms of clinical knowledge, service delivery (as appropriate for each discipline), and discharge planning.

Staffing

Community Crisis Stabilization (CCS) shall be overseen and supported by the ESP staff who relate to all ESP service components, as listed in Appendix IV, Core Staffing Pattern. The CCS is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year. CCS provides awake staffing 24/7/365. CCS utilizes a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use disorder conditions in adults The ESP/MCI ensures that all staff receive ongoing supervision appropriate to their discipline and level of training and licensure, and in compliance with MBHP's credentialing criteria. For CPSs and Family Partners, this supervision includes peer supervision.

5. Mobile Crisis Intervention Services (MCI)

Description

MCI shall be integrated into the ESP's infrastructure, services, policies and procedures, staff supervision and training, and community linkages. All ESP services for MassHealth-enrolled children and adolescents shall be provided through the ESP's Mobile Crisis Intervention services and staff.

Mobile crisis intervention services are an integral part of a comprehensive behavioral health crisis services continuum and a key strategy in reducing the use of unnecessary hospital emergency department (ED) and inpatient psychiatric services.

For children and adolescents, the best practice for delivering crisis services is via discreet and minimally disruptive mobile response to a natural setting such as the child's home or school, or a neutral community-based site. The delivery of strengths-based and solution-focused intervention is aimed at resolution of the crisis, mobilization of natural supports, and rapid linkage to the right level of care. Mobile Crisis Intervention delivers services that are consultative and collaborative, placing a high value on achieving a least restrictive, consensus disposition while ensuring access to medically necessary services.

The services are provided in the home, school, or other community-based location and are consensual in nature. Delivery of services in the home or school allows the service provider to take into consideration observations about the environment, gain understanding of culture, interact with family members or other supports, and identify risks. The expectation by service recipients, family members, and care providers – including those in residential facilities, schools, nursing homes, group homes, and shelters – that hospitalization or other placement will result from the intervention is lowered. When mobile crisis intervention services are delivered in schools, residential facilities, nursing homes, group homes, and shelters, mobile crisis professionals have the opportunity to interact with, and educate colleagues about, the system, commitment guidelines, risk management/safety planning, and risk assessment and reduction – interactions that can have positive impact well-beyond the immediate situation.. Mobile crisis intervention professionals are well poised to serve as advocates, educators, system ambassadors and mediators, consultants, and coordinators of care. While mobile care is generally the optimal service delivery option, mobile crisis professionals and teams, guided by ESP developed policies and procedures, retain discretion in choosing whether to begin or continue a mobile intervention based on identified risk factors. Safety of service providers (whether delivering mobile or site-based services) is a first priority, and this factor should be integrated in all aspects of operating a mobile crisis team, including but not limited to, guidelines in driving, navigating, use of maps, cell phones, GPS devices, environmental scanning, ensuring personal safety, identifying exceptions to mobile response, and involving law enforcement agencies. Though not acceptable as a standard method of response, there are times when first response by law enforcement, or co-response by law enforcement and the mobile crisis professional/team, are indicated, and ESPs are strongly encouraged to affiliate with law enforcement agencies to develop these response protocols.

Mobile Crisis Intervention services provide a short-term service that is a mobile, on-site, face-to- face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, seven days a week, 365 days a year. The service includes an intervention that may be up to seven (7) days duration encompassing:

- A crisis assessment, including:
  - Conducting a mental status exam
  - Assessing crisis precipitants, including psychiatric, educational, social, familial, legal/court related, and environmental factors that may have contributed to the current crisis (e.g., new school, home, or caregiver; exposure to domestic or community violence; death of friend or relative; or recent change in medication)
  - Assessing the youth's behavior and the responses of parent/guardian/caregiver(s) and others to the youth's behavior
  - Assessing parent/guardian/caregiver strengths and resources to identify how such strengths and resources impact their ability to care for the youth's behavioral health needs
  - Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care
  - Assessing medication compliance and/or past medication trials

  - Assessing safety/risk issues for the youth and parent/guardian/caregiver(s)
  - Taking a medical history/screening for medical issues
  - Assessing current functioning at home, school, and in the community
  - Identifying current providers, including state agency involvement
  - Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the youth and parent/guardian/caregiver(s)
  - Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support
  - Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face or by phone from an on-call child psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist
  - Introduction of Crisis Planning Tools, and assistance in the developing a plan if the youth/family does not already have one , including the elements delineated in the Mobile Crisis Intervention Performance Specifications located in Appendix II. See also Crisis Planning Tools: Companion Guide for Providers located at http://www.masspartnership.com/provider/CrisisPlanning.aspx

- Crisis intervention, including
  - Solution-focused crisis counseling
  - Brief interventions that address behavior and safety

- Continued delivery of crisis treatment, stabilization and support services for a period of up to 7 days from the initiation of the crisis service, during which time the ESP shall provide follow up services as indicated, including on-site face-to-face therapeutic services, psychiatric consultation, urgent psychopharmacology intervention, and/or collateral consultation

- Referrals and linkages to family's preferred, chosen and medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care and the Children's Behavioral Health Initiative (CBHI) services.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff shall coordinate with the youth's ICC care coordinator throughout the delivery of the service Mobile Crisis Intervention also shall coordinate with the youth's primary care physician, any other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

The primary objectives of Mobile Crisis Intervention services are as follows:

- Early intervention in behavioral health crises with family preservation and community-tenure serving as highly valued priorities
- Delivery of a comprehensive crisis service focused on the child and family that includes a crisis assessment, a course of intervention, stabilization of crisis, creation of a risk management/safety plan, and linkage as needed to other services

- Referral to least restrictive and least intensive treatment services consistent with medical necessity and personal and community safety, that serve to divert unnecessary deep-end services or interventions such as inpatient hospitalization, as well as residential treatment services or detention to the extent that utilization results from the youth's behavioral health condition
- Connection and coordination of care for children and their families who qualify for CBHI services
- Ensuring family connection with the services, which are chosen with the family to meet the child's and family's needs, that will promote recovery, family skill-building, and natural family and community support
- Provision of a brief period (up to 7 days) of follow-up treatment services and supports to ensure crisis resolution and effective connection to ongoing, medically necessary services

Effective Mobile Crisis Intervention shall produce the following outcomes:

- Increased confidence by child and family in crisis self-management
- Increased use of natural supports
- Timely and increased connections to community services
- Timely follow-up with child's treatment service
- Decreased use of hospital emergency departments (EDs)
- Reduced use of inpatient psychiatric services

Effective Mobile Crisis Intervention may also contribute to the following additional outcomes, to the extent the use of these resources may result from a youth's behavioral health condition:

- Reduced referrals into residential treatment
- Juvenile court/DCF diversions
- Fewer days out of the home

ESP services for children and adolescents shall be provided by the ESP's Mobile Crisis Intervention services in the community as described above unless the child, parent, or caretaker prefers to receive these services in another setting such as the community-based location. Or, the ESP may assess that there is a clinical or safety need that contraindicates providing services in the home and indicates the need to use the ESP's community-based location or other setting for a given child or adolescent. Crisis assessments for youth only occur in a hospital emergency department (ED) if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuse required consent for service in the home or alternative community settings; or if the request for Mobile Crisis Intervention services originates from a hospital ED. In those instances in which a youth is brought or sent to a hospital ED before the ESP is called or as determined by the ESP during the triage call, or because the parent or child chooses to go to the ED at any time they believe that the child requires services to treat an Emergency Medical Condition, the Mobile Crisis Intervention staff mobilizes to the ED. The number of hospital-based interventions will be closely monitored to ensure that mobile crisis intervention services are delivered primarily in community settings.

Staffing

Mobile Crisis Intervention service shall be overseen and supported by the ESP staff who relate to all ESP service components. Please reference Appendix II, Mobile Crisis Intervention- Staffing for a list of required staff and credentials.

"Emergency Services Program: Staffing." This service component shall be further supported by a dedicated program manager who shall be responsible for managing the Mobile Crisis Intervention service in compliance the MCI Performance Specifications. This service shall be further staffed by child-trained clinicians and paraprofessionals who will work in a braided fashion to ensure crisis resolution and successful linkage. Paraprofessionals who are part of the teamed response to youth and families shall generally meet the definition of and be trained as Family Partners, who have lived experience as a primary caretaker of a child with Serious Emotional Disturbance. ESPs shall be expected to ensure that at least one of their Bachelor's level staff members are in fact Family Partners. Regardless, the role of the second person on the team is to pay attention to and support the specific experience of the parent(s) whose child is in the midst of a serious health event.

6. Runaway Assistance Program

Description

As a component of the Mobile Crisis Intervention program, providers shall be responsible for the provision of Runaway Assistance in the community 24/7/365 to youth between the ages of 6 to 18. The ESP/MCI Provider shall establish a Mobile Crisis Intervention/Runaway Assistance Program ("MCI/RAP") to provide a temporary and safe place for youth to stay on a voluntary basis, until such youth is transferred to another appropriate service provider.

The primary tasks of the RAP Provider are as follows:

- Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.
- Maintain an MCI/RAP site where police can bring youth during non-court hours.
- Greet police officers and youth who come to the MCRI/RAP site during non-court hours;
- Supervision at least a one-to-one basis until the youth:
  - Is transferred to a hospital level of care
  - Is transferred to the care of ALP staff, or
  - Voluntarily leaves the site
- If a youth who is brought to the MCI/RAP site chooses to voluntarily leave:
  - Immediately notify the police department of the city or town where the MCI/RAP site is located and the DCF (if the youth is known to be in DCF custody);
  - Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123 §12, and, if determined appropriate, apply for hospitalization, and
  - Submit a critical incident report form to MBHP
- Designate a manager to oversee the MCI/RAP

The MCI/RAP manager designated by the ESP/MCI shall oversee the MCI/RAP and shall also:

- Ensure the MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court ours and be available to MCI/RAP staff for consultation
- Provide back-up coverage for on-call MCI/RAP staff
- Train program staff regarding MCI/RAP procedures
- Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP, and
- On the business day following the arrival or transfer of a youth, follow up with the police department, and follow-up with any ALP to which the youth was transferred

The ESP/MCI shall provide quarterly and annual reports to MBHP in a form designated by MBHP on outcomes and outputs related to the MCI/RAP, including, but not limited to:

- The number of youth who receive a crisis intervention assessment
- Demographics related to youth served including, but not limited to, age, gender, ethnicity and city/town of residence
- The number of youth unable to be maintained safely at the MCI/RAP site and who require further assessment in the secure environment of the emergency department
- The number of youth transferred to the care of ALP staff, and
- The number of youth who voluntarily leave the MCI/RAP site

E. Linkages

The ESP has a clear command of the local community crisis continuum - the strengths and limitations, resources, barriers, and practice patterns – and, in collaboration with MBHP, initiates strategies aimed at strengthening service pathways and the safety net of resources. ESP staff is knowledgeable of available community mental health and substance use disorder services within their ESP catchment area and statewide as needed, including the MBHP levels of care and their admission criteria, as well as relevant laws and regulations. They also have knowledge of other medical, legal, emergency, and community services available to the Member and their families, including recovery-oriented and consumer-operated resources and resources.

The ESP also communicates, consults, collaborates, refers to, and ensures continuity of care with many other resources involved with utilizers of ESP services including, but not limited to, the following:

- Primary care services and hospitals
- State agencies
- Schools
- Residential programs
- Law enforcement entities

The ESP develops and maintains close working relationships with recovery-oriented and consumer-operated resources in its local community, including but not limited to Recovery Learning Communities (RLCs), Clubhouses, and AA/NA. The ESP develops specific linkages with the RLCs relative to warmline services, if offered by their local RLC. These working relationships are expected to be with recovery-oriented and consumer-operated

organizations that support not only adults but youth and families as well.

With Member consent, the ESP collaborates with the Member's PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications.

The ESP develops and maintains relationships with the hospitals in its catchment areas characterized by ongoing and consistent communication, problem solving, planning and innovation. The ESP works with the ED to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services, as well as how to best care for Members who present for services in both the ED and ESP settings. The ESP negotiates roles with the ED, develops contingency plans for fluctuations in utilization, and creatively uses hospital and community resources to meet the needs of its communities. The ESPs/MCIs are required to collaborate with the ED to ensure that proper documentation of any intervention within the ED is appropriately shared with that facility.

Other linkages with behavioral health continuum for youth

The ESP develops and maintains linkages relevant to services for children, adolescents, and families, as required in the MCI performance specifications. This knowledge includes ESP staff being fully aware of, and knowing how to access, CBHI services.

When serving a youth (up to age 21) who is receiving ICC or In-Home Therapy Services, ESP staff shall work closely with the youth's care coordinator or therapist throughout the delivery of the service.

- ESP staff, with informed consent, shall connect children and families to mutually agreed-upon CBHI services. If it appears that more than one service may be useful to the family, ESP staff shall connect the family to the CSA so that a plan of service can be developed.
    - ESP staff shall support linkages with the family's natural support system, including friends, family, faith community, cultural communities, and self-help groups (e.g., Parental Stress Line, AA, PAL, etc.).

Other linkages

ESPs shall disseminate information about community resources that will aid in the amelioration of stressors, including those that offer food, clothing, shelter, utility assistance, homelessness support, supported housing, supported employment, landlord mediation, legal aid, educational resources, parenting resources and supports, etc.

F. Recovery-Oriented Services

Background

ESPs shall deliver services in a manner that is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) consensus statement on mental health recovery,[2] which states:

> *"Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, as the 'single most important goal' for the mental health service delivery system."*
>
> *"To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. Over expert panelists participated, including mental health consumers, family members, providers, advocates researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels."*

The following consensus statement was derived from expert panelist deliberations on the findings:

> "*Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."*

The 10 Fundamental Components of Recovery

SAMHSA's consensus statement on mental health recovery identified the following fundamental components of recovery that ESP providers are expected to integrate into their service delivery. It is reproduced here from that document.

Self-direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and person-centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations.

[2] U.S. Department Of Health And Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services, www.samhsa.gov

Individuals also identify recovery as being an ongoing journey and an end-result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions – including the allocation of resources – that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, or employee). The process of recovery moves forward through interaction with others in supportive, trust- based relationships.
Peer support: Mutual support – including the sharing of experiential knowledge and skills and social learning – plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers – including protecting their rights and eliminating discrimination and stigma – are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery

process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Description

Recovery-oriented values, principles, practices, and services have been integrated into the program model described in this document. To summarize, ESPs shall support resiliency, rehabilitation, and recovery of all individuals to whom they provide emergency behavioral health services, by integrating mental health, substance use, and co-occurring rehabilitation and recovery principles and practices throughout the service delivery model and implementing specific recovery-oriented services, including peer specialist and family support services. All program policies and procedures are designed to promote acceptance of Members into their contracted services within an atmosphere of trust at all levels of motivation and readiness and with any reasonable personal preferences.

All ESPs shall be required to employ one or more Certified Peer Specialists (CPS) to work in the ESPs' community-based locations. Additionally, there is bachelor's level staff in the staffing patterns for the ESPs' Adult Mobile Crisis Intervention services and adult Community Crisis Stabilization programs (CCSs), and ESPs will be encouraged to hire those who are also credentialed as a CPS. As described above, Certified Peer Specialists shall provide support and information to consumers while they are receiving services at the ESP community-based locations and may assist ESP clinicians in arranging the services needed for individuals after the ESP intervention. In the Adult Mobile Crisis Intervention services, the bachelor's level staff, some of whom shall also be CPSs, shall accompany the master's level clinician on mobile visits. Similarly, the staffing pattern for Mobile Crisis Intervention includes paraprofessional staff, many of whom shall also be Family Partners. ESPs shall be specifically required to hire at least one FTE Family Partner in their Mobile Crisis Intervention program. Family Partners have lived experience as a primary caretaker of a child with Serious Emotional Disturbance. These staff shall provide support to youth during their involvement in the Mobile Crisis Intervention services.

The ESPs shall also develop and maintain close working relationships with local programs that complement and integrate their services with the following formal and informal resources and programs:

a. Recovery-oriented and peer-operated services and supports;
b. Wellness programs that promote skill-building, vocational assistance, supported employment, and full competitive employment;
c. Natural community supports for Members and their families;
d. Self-help including Anonymous recovery programs (e.g., 12-step programs) for Members and their families; and
e. Consumer/family/advocacy organizations that provide support, education, and/or advocacy services, such as Parent/Professional Advocacy League (PPAL), the Federation of Children with Special Needs, Recovery Learning Communities

(RLCs), Clubhouses, the National Alliance on Mental Illness (NAMI), etc.

G. Services for Special Populations

Background

ESP services must be relevant to the age, level of development, culture, values, beliefs, and norms of all individuals who seek services and their families. Both the content of the assessment and intervention, as well as the manner in which these services are delivered, must be informed by knowledge, respect for, and sensitivity to the individual's clinical and cultural context and provided in his/her preferred language and mode of communication. Ensuring that ESP services are relevant to all populations is a great challenge given the broad range of populations who utilize these services, and doing so involves strategies at both the local and statewide levels of the ESP system.

The ESP ensures that service delivery facilitates communication, access, and an informed clinical approach with special populations including but not limited to:

- Intellectual and developmental disabilities
- Deaf and hard of hearing
- Blind, deaf-blind, and visually impaired
- Culturally and linguistically diverse populations
- Elders
- Veterans
- Homeless
- Gay, lesbian, bisexual, transgendered

The needs of specific or "special" populations may be characterized relative to one of the following, which are not intended to be mutually exclusive:

Communication: Individuals with communication needs will be able to benefit from the core ESP service, but require the facilitation of communication, such as through language interpreters, American Sign Language interpreters, TTD, or Braille materials.

Access: Some individuals require support, accommodations, assistance, and/or service delivery in a particular venue to gain access to ESP services. Once accessed, these individuals are able to benefit from the core ESP service. Access needs may include specific education and outreach, the availability of mobile evaluations for populations who are unable or reluctant to seek services in the community, transportation, an environment that is welcoming and inclusive, etc. For example, many elders require mobile crisis intervention services provided in their homes, due to their medical conditions and/or difficulty leaving their homes and/or reluctance to use behavioral services, particularly in traditional settings.

Informed clinical approach: For some individuals, an informed clinical approach is needed in the implementation of the core ESP service. ESP clinicians must have understanding and sensitivity to both the unique clinical and cultural context of these populations in conducting the core ESP

services of assessment, crisis intervention, and stabilization. This sensitivity means, for example, that in addition to utilizing appropriate means of communication with an individual who is deaf, it is equally important to understand deaf culture and assess the individual in that context.

Unique clinical service: Services to individuals may require the use of specialized assessment tools or techniques that vary substantively from those normally used in providing core ESP services. Examples may include a different approach to clinical engagement, different means of gathering information, and collection of different than usual content that must be included in the assessment to inform the diagnosis and disposition, such as for individuals with intellectual disabilities.

Please note that the following are not identified as "special populations" because these populations represent the majority of individuals who utilize ESP services, and their needs are addressed throughout the program model described in this document. ESPs shall ensure that all ESP clinicians and other staff receive training and meet core clinical competencies in serving the following populations:

- Children, adolescents, and their families
- Adults
- Persons with mental health conditions
- Persons with substance use condition
- Persons with co-occurring mental health and substance use condition

Local ESP response to special populations

The responses to the needs of special populations at a local ESP level shall therefore include:

- *Access*: Each ESP shall be required to articulate and implement specific outreach and other strategies to ensure access to ESP services for each identified special population.
- *Core clinical competency*: In order to provide an informed clinical approach in the crisis assessment and intervention with individuals in each identified special population, each ESP shall be required to ensure that ESP clinicians receive training and meet specified core clinical competencies relative to each.
- *Special services*: All ESPs shall ensure staff training and other mechanisms for providing an ESP service appropriate to individuals with intellectual and developmental disabilities. Some ESPs shall also offer specific services to some other special populations, based on the needs of their local communities and the prevalence of given populations therein. For example, an ESP may develop a mobile crisis intervention team to respond to a certain high incidence culturally or linguistically diverse population in a given area.

Statewide support from state agencies

In order to support ESPs in responding to special populations, DMH, MassHealth, and MBHP will work with state agencies to identify central office and local contacts that can be available to consult with each ESP on available resources and systems issues relative to their constituents. Some state agency staff may also be resources for clinical consultations regarding the populations they serve.

H. Hospital/Medical Interface

ESP working relationships with hospital emergency departments (EDs) in their catchment areas

The working relationship between an ESP and the hospitals in their catchment area, particularly their EDs, is critical to meeting the behavioral health needs in the communities they both serve. ESP relationships with the hospitals in their catchment areas should include ongoing and consistent communication, problem solving, and planning. ESPs and EDs must work together to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services, as well as how to best care for individuals who present for services in both the ED and the ESP settings. ESPs and EDs should negotiate roles, develop contingency plans for fluctuations in utilization, and creatively use hospital and community resources to meet the needs of their communities.

Please see Appendix I: ESP Catchment Areas, which identifies the hospital EDs located in each catchment area. Providers are expected to articulate specific strategies for collaborating with each ED to achieve the goals related to hospital utilization articulated in the section below.

ESPs shall cooperate with hospitals that require ESP clinicians to be credentialed in order to provide crisis behavioral health services in the hospital ED, in compliance with MBHP Network Alert #19 *General Hospitals Credentialing ESPs.*

ESP goals related to hospital utilization

- *Emergency department (ED) diversion*
  Subject to applicable state and federal regulations that entitle MassHealth members to seek emergency services for an Emergency Medical Condition, a priority goal of the ESP model is to interrupt patterns of over-reliance on hospital EDs as the first point of contact in the event of a behavioral health crisis. While EDs are an important component of the crisis continuum, most behavioral health crises can be readily and more effectively addressed in the community. Every ESP must be organized around the diversion of behavioral health utilization from those settings when there is not a physical condition or level of acuity that requires medical assessment and intervention, while understanding that MassHealth Members are entitled to seek emergency services in an ED if they believe they have an Emergency Medical Condition. ESPs are expected to develop and implement specific strategies to change referral and utilization patterns in their communities and shift volume from hospital EDs to their community-based services, specifically their child/adolescent and Adult Mobile Crisis Intervention services, their community-based locations, and their adult CCSs. ESPs shall create a service pathway that screens for the need to refer up to a hospital ED rather than step-down from hospital-based emergency care.

- *Timely response*
  Another priority goal of the ESP system is to respond to all requests for crisis assessment, intervention, and stabilization in a timely fashion, in order to be responsive to the

individual's and/or caretakers' sense of urgency, intervene in behavioral health crises early, and prevent the adverse impact that treatment delay may have on individuals, families, and settings in which those individuals await these services. This goal is particularly important relative to those who await ESP services in the hospital ED setting. Although the ESPs will be working toward the goal of decreasing behavioral health utilization in the ED setting, some individuals are expected to continue to present at EDs if they believe they have an Emergency Medical Condition. It is critical for ESPs to respond quickly to requests for their services in the hospitals EDs in their catchment areas, in order to minimize the duration of individuals' time in this more restrictive setting, thereby contributing to efforts to reduce ED overcrowding and boarding. ESPs shall begin all crisis assessments requested for individuals, within the ESP scope defined in the ESP Performance Specifications, no later than one hour from the time of readiness. Please refer to Appendix II: ESP Performance Specifications and Appendix III: Quality Indicators for more information regarding response time requirements.

ESPs shall be expected to develop specific strategies with EDs in their catchment area to ensure timely access to ESP services for individuals who present in the ED seeking behavioral health services. ESPs shall negotiate arrangements with each ED, which may include, but not be limited to, ESP clinicians traveling to the ED to provide ESP services within required timeframes; the ESP outposting clinicians at the ED during specified high-volume hours; the ESP subcontracting to the ED for the hospital to directly provide the emergency behavioral health service; and/or other arrangements as identified by the ESP and negotiated with the ED. ESPs shall also educate EDs about other behavioral health services to which individuals may be triaged, such as ATS or urgent outpatient services. When ESPs respond to individuals who have presented in an ED, the ESP shall be required to meet a response time requirement of no longer than one hour, and they shall be responsible for providing the core ESP service of crisis assessment, intervention, and stabilization.

- *Inpatient diversion*
  Strategies that reduce unnecessary psychiatric hospitalization help to preserve the availability of this vital community resource in instances when it is needed. Persons who receive behavioral health crisis services in a hospital ED are more likely to be hospitalized than those treated in the community. Providing ESP services in alternative community-based locations will increase the likelihood of referral to appropriate, timely, and least-restrictive ongoing services in lieu of an inpatient psychiatric admission. In addition, ESPs shall be expected to work with EDs to identify and implement additional specific strategies to maximize utilization of community-based diversionary services (including rapid linkage to treatment) in a manner that is consistent with medical necessity criteria. Please refer to Appendix III: Quality Indicators for more information regarding disposition goals.

- *Medical evaluation*
  During a behavioral health crisis, a small percentage of individuals require medical evaluation to assess and/or treat a medical condition that may or may not be contributing to their behavioral health condition. Most individuals do not require general medical

evaluation, beyond screening, as part of a crisis assessment and intervention. Given that the majority of ESP services shall be provided in the community rather than in hospital EDs, ESPs will be expected to develop protocols and strategies to support ESP staff in screening individuals for the need for medical evaluation, based on the *Medical Clearance Guidelines for Emergency Service Programs (ESP) & Acute Inpatient Facilities: A Consensus Statement* developed by task force members of the Massachusetts College of Emergency Physicians and the Massachusetts Psychiatric Society. ESPs shall refer differentially to hospital EDs and primary care clinicians, within a timeframe that is based on the urgency of that need. It will be important for ESPs to develop and maintain protocols with their local EDs in order to ensure access to medical evaluation for individuals who require this service and have come to the ESP's attention in their community-based location or through their mobile crisis intervention services.

IV. PROVIDER QUALIFICATIONS

A. Qualifications to Bid on an ESP Contract

The qualifications of a provider agency seeking to apply for selection as an ESP are outlined below. Each contract will be issued to one provider who may enter into subcontracts with other organizations for the purpose of delivering ESP services.

Required qualifications

- Licensed as an outpatient mental health clinic by the Department of Public Health (DPH) or licensed as a hospital by the DPH and/or the Department of Mental Health (DMH)
- A currently contracted MassHealth provider; a provider with the intent to become a contracted MassHealth provider within 3 months of contract award; or an organization of DMH employees pursuant to M.G.L. c.7 §54(5) and committed to becoming a contracted MassHealth provider within 3 months of the contract award.
    - Pursuant to M.G.L. c. 7 § 54(5), DMH will provide resources and assistance to an organization of DMH employees interested in submitting a bid to provide the services that are the subject of this RFR.
- At least three years' experience providing behavioral health services to a wide range of populations, including children, adolescents, and adults
- Organizational infrastructure to provide clinical, medical, quality, technical, and financial oversight and management of all components of the ESP program described herein
- Ability to fully implement all aspects of the ESP program model contained herein within 3 months of award and comply with all requirements
- ESP core competencies articulated in Section II. H., including, but not limited to, capacity and preferably direct experience in providing and managing:
    - Crisis services
    - Mobile services

  - Recovery-oriented services
  - Culturally and linguistically competent services
  - Services tailored to meet the needs of special populations
  - Quality improvement
  - Intersystem planning and affiliation
- Demonstrated knowledge of the community's needs and resource, particularly the local community crisis continuum and its strengths and limitations, resources, barriers, and practice patterns, as well as established relationships with stakeholders therein

Preferred qualifications

- Physical presence in catchment area
  - An established physical location within the catchment area for a minimum of one year prior to the submission of an application for an ESP contract is preferred.
  - Consideration will be given to provider agencies with a physical location within the catchment area for less than one year.
  - Further Consideration will be given to provider agencies with a physical location in a contiguous catchment area for a minimum of one year.
  - If your organization does not already have a physical location in an area where you would like to be an ESP, you will be asked in the Response Requirements Section of this RFR to include a detailed plan for how your organization will successfully establish a physical location in the catchment area by the expected start date and a strong rationale as to why you wish to operate in the catchment area.

B. Qualifications for an ESP Provider to Directly Implement the Mobile Crisis Intervention Component

ESP bidders, who meet the criteria above, "Qualifications to bid on an ESP contract," must also demonstrate significant expertise in providing and managing services for children, adolescents, and their families by demonstrating substantial evidence of the characteristics below if they plan to directly implement the Mobile Crisis Intervention component of their ESP program. Bidders should document experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis intervention, and/or treatment services, including:

- Administrative infrastructure that supports the delivery of Mobile Crisis Intervention services 24/7/365, including access to consultation with a child-trained supervisor and board-certified or eligible psychiatrist
- Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels, in providing behavioral health services to children, adolescents, and their families
- Relationships with child- and family-focused community resources in the service area
- Membership in child-advocacy and/or child-focused trade organizations

- Competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services and integrating youth and family voice in organization governance
- Outcomes data, quality improvement processes, and satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families
- Demonstrated knowledge, commitment, and experience implementing services to children, adolescents, and families consistent with *Systems of Care* and *Wraparound* principles
    - Youth-centered and family-focused
    - Individualized
    - strengths-based
    - Partnership with families and youth
    - Reflective of youth and family values and preferences
    - Culturally and linguistically competent
    - Collaborative
    - Team-based, delivered in partnership with youth and family
    - Community-based, takes place in the least restrictive setting possible that safely promotes youth and family integration into home and community life
    - Coordinated services and community supports
    - Inclusive of natural supports (e.g., extended family networks, faith-based organizations)
    - Least restrictive, appropriate setting
    - Planned transition to adult services
    - Individual and system outcome measurements
    - Continuous quality improvement
- Demonstrated broad knowledge of the community behavioral health system for children, adolescents, and families including Child Behavioral Health Initiative (CBHI) services.
- Demonstrate strategic initiatives to strengthen collaboration with local CBHI providers.

C. Subcontracts

Bidders must propose program models in which they, as the contracted ESP provider, will directly provide the majority of ESP services themselves, i.e., with staff employed by the contracted provider. Bidders may propose subcontracts for one or more

- ESP service components throughout the catchment area

- ESP service components for a given population or geographic area within the catchment area

Bidders who qualify as a licensed outpatient mental health clinic must operate the ESP community-based location. Bidders who qualify as a licensed hospital may subcontract out for the ESP community-based location. In all cases, the bidder's proposed program model must ensure that strategies to promote community based responses are integral.

Designated EDs

An ESP may choose to sub-contract ESP services to an ED for Member's age 21 and older who present for emergency behavioral health services at that designated ED. This model may be advantageous to ESPs that have high volume EDs in their catchment area.

The ESP must retain programmatic and performance oversight and administrative responsibilities of a subcontracted component of service.

Subcontractor requirements

All subcontractors must meet the same requirements as the ESP, except consideration will be given to:

- Subcontractors that may be in process of becoming a MassHealth-contracted provider
- Subcontractors must have at least one year experience providing behavioral health services.

Subcontractors for the Mobile Crisis Intervention services must also meet the requirements for providers of that service component as described in section I.V.B. above.

D. Additional Requirements Pursuant to Massachusetts Privatization Law

Bidders must agree to implement the following pursuant to the Massachusetts Privatization Law codified in M.G.L. c.7 §§ 52, 53, 54, and 55:

- Offer available positions to qualified DMH employees whose employment is terminated as a result of this contract, and who satisfy the hiring criteria of the successful bidder;
- Comply with a policy of nondiscrimination and equal opportunity for all persons protected by Chapter 151B and take affirmative steps to provide such equal opportunity for all such persons;
- Provide health insurance to each employee and the employee's spouse and dependent children for employees who work 20 hours or more a week under the contract, and pay not less than a percentage, comparable to the percentage paid by the Commonwealth for state employees, toward the cost of this health insurance. For state fiscal year 2015, the Commonwealth contributed 80% toward the cost of health insurance for DMH employees. The successful bidder must pay for employee health

insurance at no less than the rate the Commonwealth pays for DMH employees for state fiscal year 2016 for the contract period;[3]

- Pay the minimum wage rate identified in Appendix V for each position in which the bidder will employ any person to perform duties that are substantially similar to the duties currently performed by regular DMH employees; and
- Submit quarterly payroll records to MassHealth pursuant to M.G.L. c. 7 §54(2).

Bidders must also comply with any relevant federal or state regulatory statutes including, but not limited to statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest.

V. PERFORMANCE REQUIREMENTS

A. General Performance Specifications

All providers responding to this RFR agree to abide by the MBHP General Performance Specifications. This "general" performance specification applies to all MBHP network providers at all levels of care. Additionally, **providers will be held accountable to the service-specific performance specifications for each level of care for which they are contracted.** For ESP providers, the following service-specific performance specifications will apply: ESP, Mobile Crisis Intervention, and Adult Community Crisis Stabilization. See the General Performance Specifications located in Appendix II.

B. ESP Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for Emergency Services Program services. See the performance specifications located in Appendix II.

C. Mobile Crisis Intervention Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for Mobile Crisis Intervention services. See the performance specifications located in Appendix II.

D. Adult Community Crisis Stabilization (CCS) Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for adult CCS services. See the performance specifications located in Appendix II.

[3] The Commonwealth's employer contribution rate for state employee health insurance for state fiscal year 2016 is expected to be no more than 80% and may possibly go down. The FY 2016 Commonwealth health insurance contribution rate will be included in the FAQs to be released on August 5, 2015. For planning purposes, bidders should assume the FY 2016 rate will be no higher than 80% and use that rate as a placeholder until the actual FY 2016 rate is made available.

VI. PROCUREMENT PROCESS

A. Timeline

RFR COMPONENT	DATE
RFR release	July 6, 2015
Question submission begins	July 6, 2015
Bidders' conference	July 22, 2015
Question submission deadline	July 27, 2015
FAQ release date	August 5, 2015
Letter of Intent deadline	August 10, 2015
RFR response deadline	September 1, 2015
Recommendations forwarded to State Agency	September 25, 2015
Bidder's notified of recommendations	September 28, 2015
Award date	Dependent upon review by the State Auditor
Implementation	Within ninety (90) days of the final contract award date

B. Bidders' Conference

A bidders' conference will be conducted to allow potential bidders the opportunity to ask clarifying questions about the RFR.

The bidders' conference is not mandatory; however, potential bidders are encouraged to send one or two representatives to the conference. We recommend bringing a copy of the RFR to the conference to reference during the discussion.

Date: July 22, 2015

Time: 10:00 a.m. to 12:00 p.m.

Location: One Lakeshore Center, 3rd Floor
Bridgewater, MA 02324

C. Written Questions

Clarifying questions concerning this RFR will also be accepted in writing. They must be submitted by July 27, 2015. Questions can be sent to ESPRFR@valueoptions.com. Questions will not be answered on an individual basis.

D. Frequently Asked Questions (FAQ)

Responses to frequently asked written questions and frequently asked questions from the bidders' conference will be posted by close of business on August 5, 2015 at http://www.masspartnership.com/provider/ESP/2015ESPRFR.aspx. It is the responsibility of the bidder to check the web site for updates.

E. Letters of Intent

Any bidder planning to submit an RFR response for one or more ESP catchment areas must submit separate letters of intent for each catchment area by 5 p.m. on August 10, 2015. Bidders must utilize the Letter of Intent for located in Appendix VI for this purpose.

The Letter of Intent form should be sent to:

Shelley Baer, M.S.
Director of Emergency Services
Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118-5002

- **Letter of intent forms may be submitted by email or postal mail. Faxed forms will not be accepted.**
- **Any letter of intent not meeting the response deadline will not be accepted or considered. Additionally, any RFR response that was not preceded by a letter of intent will not be accepted or considered.**
- **If no letters of intent are submitted for a given service area, MBHP will post those service areas on the web sites and will invite letters of intent for those service areas only within a specified extended timeframe.**

F. Response Submission Deadline and Requirements

In order for responses to be considered, each bidder must meet all the following submission requirements for each catchment area on which the provider is bidding:

- Submit an electronic copy of the response via e-mail **and**
- Deliver one (1) bound original and four (4) unbound copies of the completed response and all required attachments in a package or box labeled with the bidder's name, address, and catchment area.
- Complete both of the above submissions **NO LATER THAN** 5 p.m. on September 1, 2015 to the following:
    - ***Electronic copies via e-mail to***: ESPRFR@valueoptions.com
    - ***Hard copies to***:

      Shelley Baer, M.S.
      Director of Emergency Services
      Massachusetts Behavioral Health Partnership
      1000 Washington Street, Suite 310
      Boston, MA 02118-5002

It **is** acceptable for the electronic submission to include the cover sheet and the narrative response section only. Bidders must include attachments to the one (1) bound and four (4) unbound copies. However, bidders may choose to include attachments to the electronic submission.

Staples or paper clips should **not** be used in <u>any part</u> of the response, including the attachments. It is acceptable to use binder clips to bind the four (4) required unbound copies of the responses.

- **Any response not meeting the response deadline in full, including both the electronic and hard copies, will not be accepted or considered.**
- **Faxed transmissions are not acceptable.**
- **Submissions by postal mail must be received by the stated deadline as well.**

G. Evaluation of Responses

A selection committee comprised of MBHP staff will review the responses received by the submission deadline and make the final selections for each of the 4 catchment areas included in this procurement. Each proposal will receive a score based on the narrative response. The selection of an ESP provider for each catchment area is based on the proposal with the highest score using a consistent point system. In addition to the total score, consideration will be given to other factors, including the committee's review of financial documents, corrective action plans and/or sanctions, letters of support, and tenure of the bidder's presence and services in the given ESP catchment area. If no acceptable proposals are received for a particular catchment area, the selection committee reserves the right to put the catchment area back out for resubmission of proposals by posting a notice on the MBHP web site.

The following table summarizes the scoring scale against which each proposal will be evaluated:

RFR Section	Maximum Points
VII.B. 1 General Qualifications and Infrastructure	30
VII.B. 2 ESP Core Competencies	100
VII.B. 3 ESP Service Components	100
VII.C Technology Specifications and Response Requirements	20
VII.D Fiscal Specifications and Response Requirements	Required Part of Submission; No Points
Maximum Total Points	250

H. Selection of Contractors

After soliciting and receiving bids, MBHP will select the winning bidder(s) on behalf of MassHealth.

Before a contract or contracts may be awarded, the state agency must submit to the State Auditor copies of the proposed privatization contract(s) and certify to the State Auditor that:

1. it has complied with all provisions of this section and of all other applicable laws;
2. the quality of the services to be provided by the designated bidder is likely to satisfy the quality requirements summarized in the Privatization Law;
3. the contract cost will be less than the estimated cost of regular DMH employees providing the subject services;
4. the designated bidder and its supervisory employees, while in the employ of said designated bidder, have no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest; and
5. the proposed privatization contract is in the public interest, in that it meets the applicable quality and fiscal standards set forth in the Privatization Law.

The final award of the contract is subject to review by the State Auditor pursuant to M.G.L. c. 7 §55(a) and contingent on a binding commitment of funding from MassHealth.

VII. RESPONSE SUBMISSION REQUIREMENTS

All questions contained within this section must be answered and all required attachments provided.

A. Format of Response

All responses to the Narrative, Technology, and Fiscal Response sections must be in the following format:

- Type-written, Times New Roman, 12-point font, single-spaced, one-inch margins
- 8 1/2 x 11 inch white paper, single-sided
- Question number (and title if applicable), followed by response. For example:

  2.1.1 Crisis services

  2.1.1.1 (response)

  2.1.1.2 (response)

Page limits are identified for each of the response sections below. We request that the narrative response section be paged numbered, with page numbers located in the lower right-hand corner of the response. Proposals with a narrative response section that does

not meet the response specification requirements outlined above will **NOT** be accepted or considered. Attachments are not included in the page limits. However, bidders should be judicious in their use of attachments and include only those required; bidders may add optional attachments only if they will help reviewers evaluate their proposals. Bidders may not submit any non-written material (i.e., videotapes, disks, etc.). Attachments **MUST** be on letter-size paper. Glossy brochures or other attachments not on letter-size paper should **not** be included as part of the submission. If these are included, they will be removed from the response, and they will not be considered as part of the response. The ONLY exception will be audited financial statements which may be on legal-size paper, though it is preferred for those documents to be on letter-sized paper.

The response must be divided in sections, in the following order:

1. **Cover sheet**
    - Complete the cover sheet found in Appendix VII.
2. **Narrative response**
    - Begin with a divider page labeled "Narrative Response."
    - Answer all questions in Section VIII.B.
    - Maximum page limits: 45-50 as specified below
        - B.1 General qualifications and infrastructure: 5 Pages
        - B.2 ESP core competencies: 15 Pages
        - B.3 ESP service components: 25 Pages
        - B.4 Additional response requirements, if applicable to bidder
            - B.4.1: 1 page
            - B.4.2: 1 page
            - B.4.3: 3 pages
3. **Technology response**
    - Begin with a divider page labeled "Technology Response."
    - Answer all questions in Section VIII.C.
    - Maximum page limit: 3 pages
4. **Fiscal response**
    - Begin with a divider page labeled "Fiscal Response."
    - Answer all questions in Section VIII.D.
    - Maximum page limit: 5 pages
5. **Attachments** *(Please place a divider page at the beginning of the Attachments and between each of the following sections of Attachments.)*
    - Narrative Response Attachments (required and optional)

- Technology Response Attachments (required and optional)
- Fiscal Response Attachments (required and optional)
- Letters of support from local organizations in the proposed catchment area such as state agencies, community agencies, consumer/youth/family organizations, cultural organizations, hospitals, and others (optional)
    - Letters should describe the specific nature of the bidder's affiliation with the local organization, the ways in which the affiliation will strengthen the bidder's ability to provide ESP services and benefit the individuals and families served, and why the local organization recommends the bidder to be the ESP provider in the proposed catchment area. No points are associated with letters of support but they will be considered in the overall evaluation of your response. If the bidder chooses to submit letters of support, these letters must be included as attachments to the submission. Please DO NOT send letters of support individually to MBHP.

B. Narrative Response Requirements

Guidelines:

- Specific responses detailing what you have done and will do will be the most helpful in evaluating your proposal.
- Bulleting/tables/charts in lieu of narrative are welcome if such a format better enables you to provide specific information in a succinct fashion.
- Please address both (1) adults and (2) children/adolescents/families throughout your response.
- Please make clear throughout the response whether you are describing current versus proposed practice at your organization.
- **Applications for More than One Catchment Area**

  For organizations interested in bidding on an ESP contract in more than one local catchment area, a separate response is required for each proposed service area. The purpose of this requirement is to ensure that all responses are specific to the needs of local communities. Bidders must describe the regional infrastructure and how they would gain efficiency/improve performance by serving more than one catchment area.

1. *General qualifications and infrastructure:* ***(30 points)***

   (Note: Please "cut and paste" questions 1.1 through 1.4.2.1 into your response.)

   1.1 Licensure:

   1.1.1 Licensed as an outpatient mental health clinic by the Department of Public Health (DPH)

   ❑ Yes ❑ No

   1.1.2 Licensed as a hospital

1.1.2.1 by the DPH ❑ Yes ❑ No

1.1.2.2 by the Department of Mental Health (DMH) ❑ Yes ❑ No

1.2 Accreditation:

1.2.1 Accredited by a national organization ❑ Yes ❑ No

1.2.2 If yes, please list accreditation(s).

_____

1.3 Currently contracted MassHealth provider or application in process: ❑ Yes ❑ No

1.4 At least three years' experience providing behavioral health services to a wide range of populations:
❑ Yes ❑ No

1.4.1 Number of years providing behavioral health services to children, adolescents, and families: _____

1.4.1.1 Number of youth served in CY14: _____

1.4.2 Number of years providing behavioral health services to adults: _____

1.4.2.1 Number of adults served in CY14: _____

1.4.3 Briefly describe the behavioral health services your organization has provided and the populations to which your organization has provided these services.

1.5 Presence in and knowledge of the catchment area for which your organization is applying for an ESP contract

1.5.1 Please complete the questions below regarding your current physical location within the catchment area for which your organization is applying for an ESP contract.

1.5.1.1 Number of years in which your organization operated an uninterrupted physical location at which you have provided direct services within the proposed catchment area

1.5.1.2 Address of location meeting the above criteria, where your organization has operated for the longest duration

1.5.1.3 If your organization does not already have a physical location in the catchment area where you would like to be an ESP, include a detailed plan for how your organization shall successfully establish a physical location in the catchment area within ninety (90) days of the contract award and a strong rationale as to why you wish to operate in the catchment area.

1.5.2 Provide a brief assessment of the proposed catchment area's needs and resources, particularly the local community's crisis continuum and its strengths and limitations, resources, barriers, gaps, and practice patterns.

1.5.3 Briefly describe your organization's established relationships with stakeholders in the catchment area and how they strengthen your ability to be effective as the potential ESP provider therein.

1.5.4 Explain how your organization interfaces with the existing crisis program in this catchment area and supports interventions that are community-based, resolution-focused and that promote community tenure.

1.6 Continuum of care: Briefly describe the continuum of care operated by your organization and how you would utilize all the resources of your organization to strengthen your ESP, meet the stated goals of ESP and this procurement, and benefit the individuals and families served.

1.7 Administrative infrastructure: Identify key staff positions within your organization and other infrastructure elements that will enable your organization to provide administrative and financial oversight and management of an ESP contract and service delivery system.

1.8 Medical and clinical infrastructure: Identify key staff positions and other infrastructure elements that will enable your organization to provide medical and clinical oversight and management of an ESP contract and service delivery system.

1.9 Quality Management (QM) infrastructure

1.9.1 Identify key staff positions and other infrastructure elements that will enable your organization to provide quality management and risk management of an ESP contract and service delivery system.

1.9.2 Required attachment: your organization's current Quality Management plan

1.9.3 Briefly describe how your organization employs quality management tools and strategies to measure, monitor, and continuously improve quality of clinical care and service delivery. (If this is adequately described in your QM plan, please indicate that here. An additional summary is then not necessary.)

1.9.4 Provide specific examples how you shall use data and information, such as those identified in Section C.4 and C.5 below, to ensure and continuously improve the quality of ESP services and the performance of the ESP contract.

2. ESP core competencies: ***(100 points)***

2.1 Crisis services

2.1.1 Please describe the experience your agency has had with providing crisis intervention services, including the specific services, clinical competencies, populations, payers, and durations of your organization's operation of such services.

2.1.2 Please describe the extent to which you have been successful in delivering services requiring crisis or rapid response. Include responses to the following items as well as attachments as needed:

2.1.2.1 Data and other information about your experience in meeting 24/7/365 response time requirements in an crisis environment and the specific strategies you shall utilize to do so as an ESP provider

2.1.2.2 Data and other information about your experience and efficiencies in providing telephonic crisis support, triaging, dispatching, and managing resources to respond quickly to fluctuations in demand in a crisis environment, across multiple venues, and the specific strategies you shall utilize to do so as an ESP provider

2.1.2.3 Data and other information about your experience in hiring, developing, and retaining staff who are competent at providing services in an emergency environment, preferably in a behavioral health crisis intervention role, are skilled at risk management, and are able to operate in an independent and self-directed fashion, and the specific strategies you shall utilize to do so as an ESP provider

2.2 Mobile services

2.2.1 Please describe the experience your organization has had with providing services on a "mobile" basis in individuals' homes and other natural settings in the community, including the specific service, population, and duration of your organization's operation of such services.

2.2.2 Please describe specific strategies you have used and/or plan to use as an ESP provider to establish a culture among your staff and within your community that values the provision of mobile services in the community as the primary and preferred service delivery model.

2.2.3 Please describe the challenges you anticipate in establishing a culture and practice of prioritizing mobile services and specific strategies you have and/or shall use to mitigate these challenges to ensure program goals are met.

2.2.4 Please describe the experience of your organization with working with and collaborating with the community behavioral health system for children, adolescents, and families including Children's Behavioral Health Initiative (CBHI) services.

2.3 Diversion

2.3.1 ED diversion

2.3.1.1 Please describe your organization's experience in achieving diversions from hospital emergency departments (EDs). Include data and the specific strategies you have employed.

2.3.1.2 Please describe how you shall create a culture within your organization and community that embraces the vision that most behavioral health crises can be effectively addressed in the community rather than in the hospital ED setting.

2.3.1.3 Please delineate specific strategies you shall implement to shift behavioral health utilization from the EDs in the proposed catchment area to community-based alternatives including the services and venues outlined in the ESP model described in this RFR. Address strategies for specific populations and stakeholders with whom you shall collaborate to achieve this goal.

2.3.1.4 Please describe the challenges you anticipate in establishing a culture and practice of shifting behavioral health utilization from hospital EDs and specific strategies you have and/or shall use to mitigate these challenges to ensure program goals are met.

2.3.2 ED-specific plans related to ED diversion and timely response

2.3.2.1 For each hospital ED in the proposed catchment area, attach a specific plan for how your organization shall collaborate with the hospital to achieve the goals related to ED diversion and ensure timely response when individuals do present in that setting. Please indicate the status of your negotiations with each hospital relative to these plans. If you have already developed a formal agreement with any hospitals, please attach those agreements. In each attached hospital-specific plan:

2.3.2.1.1 Please describe how you shall work with the hospital in an ongoing, collaborative, and integrated fashion.

2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served by that hospital, and the community serviced by that hospital--for how you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP's alternative community-based settings and services.

2.3.2.1.3 Describe how you will minimize the need for ED "boarding" and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.

2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. Based on historical volume, what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis, and adjust staffing to meet the need?

2.3.2.1.4.1 Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED? (e.g. designated ED). If

so, please indicate which ED(s) you will enter into a subcontract with.

2.3.2.1.4.2 If yes, describe how the above will be a value-add to the crisis system of care

2.3.3 Diversion from unnecessary psychiatric hospitalization and other out-of-home placement

2.3.3.1 Please describe your organization's experience in collaborating with individuals in crisis in developing alternatives to avoidable psychiatric hospitalizations and other out-of-home placements.

2.3.3.2 Please describe how you shall create a culture and educate others in your organization and community, including families, stakeholders in hospital EDs, state agencies, and others, to foster acceptance of community-based alternatives rather than defaulting to inpatient psychiatric care.

2.3.3.3 Please delineate specific strategies and resources you shall leverage in order to maximize the use of diversionary services as alternatives to inpatient psychiatric care and other out-of-home placement.

2.3.3.4 If implementing a "designated ED" model, explain how you will ensure this happens if individuals are seen in the designated ED

2.4 Recovery-oriented services

2.4.1 Hiring practices

2.4.1.1 Please describe your organization's experience in recruiting and hiring personnel who are recovery-oriented in their beliefs.

2.4.1.2 Please describe specific strategies you have used and/or plan to use to recruit recovery-oriented personnel specifically in your ESP program

2.4.2 Integration of peers and family members

2.4.2.1 Describe how your organization's commitment to recovery-oriented services is and/or shall be reflected in areas such as board membership, committee membership, and organizational policies and procedures.

2.4.2.2 Please describe your organization's current and planned use of peers and family members in consultative, training and service delivery capacities.

2.4.2.2.1 Include specific strategies and implementation plans you shall employ to hire and integrate Certified Peer Specialists and Family Partners into your ESP staffing and services including the specific role and functions of Certified Peer Specialists and Family Partners. Address how you shall ensure that these staff members have access to peer supervision in an ongoing fashion.

2.4.3 Adherence to recovery principles

2.4.3.1 List, or attach, professional development activities and trainings that your organization has provided for staff at all levels of the organization relative to resiliency, rehabilitation, and recovery within the two years prior to the due date for your RFR response.

2.4.3.2 Please describe how your organization ensures and/or plans to ensure integration of recovery principles into practice, including those listed in Section II.B Core Competencies, under "recovery oriented treatment" and Section II.C Clinical Competencies under "recovery-promoting treatment approach."

2.4.3.3 Please describe the challenges, if any, you anticipate in shifting fully to a recovery-orientation and specific strategies you shall utilize to mitigate those challenges to ensure program goals are met.

2.5 Culturally competent services

2.5.1 Population and related experience

2.5.1.1 Describe the racial, ethnic, cultural, and linguistic composition of the population in the catchment area for which your organization is applying for an ESP contract.

2.5.1.2 Document your organization's experience in providing services to the cultural and linguistic populations in the proposed catchment area, including data.

2.5.1.3 Describe any culturally and linguistically tailored program models that you currently operate. Describe the degree to which the staff and management of these programs reflect the cultural and linguistic populations served.

2.5.1.4 Describe your organization's current or planned efforts to engage populations your organization believes are underutilizing or not fully benefiting from ESP services in the catchment area for which your organization is applying for an ESP contract.

2.5.2 Organizational capacity

2.5.2.1 Describe your organization's capacity to provide culturally and linguistically competent behavioral health services to children, families, and adults including the extent to which your organization's staff and governance reflect the significant cultural and linguistic populations within the ESP service area as well as your efforts to ensure that all staff members develop cultural competence. Address:

2.5.2.1.1 current composition of governance and senior management relative to this issue;

2.5.2.1.2 any initiatives undertaken in the past two years by your organization's Board of Directors to strengthen the cultural diversity of Board and/or senior management, and the results of those efforts;

2.5.2.1.3 the number of bilingual/bicultural staff employed by your organization and the extent to which your direct care staff reflect the significant MassHealth-enrolled cultural and linguistic populations in the proposed catchment area;

2.5.2.1.4 your organization's access to interpreter services (including ASL) for whom the organization does not currently have sufficient bilingual/bicultural staff; and

2.5.2.1.5 list or attach professional development activities and trainings that your organization has provided for staff at all levels of the organization relative to cultural competence within the two years prior to the due date for your RFR response.

2.5.2.2 Describe or attach any of the following that are currently in place within your organization with regard to delivering culturally and linguistically competent care: mission statements, definitions, policies, and procedures reflecting the organization's dedication to providing culturally competent care.

2.5.2.3 Document any organizational initiatives undertaken within the past two years to strengthen cultural and linguistic competency or capacity.

2.5.3 Describe any experience you have had in forming partnerships with minority, community-based organizations, mutual assistance agencies, or multi-service agencies for immigrants and refugees to meet the care and support needs of clients.

2.6 Other special populations: Describe your organization's experience and expertise in providing behavioral health services to the following populations, and articulate how you shall modify your program, offer specific ESP service components, and/or otherwise ensure access to ESP services for these populations as well clinically appropriate assessment and intervention.

2.6.1 Elders

2.6.2 Veterans

2.6.3 Persons who are homeless

2.6.4 Persons with substance use conditions

2.6.5 Persons with co-occurring mental health and substance use conditions

2.6.6 Persons who are deaf and hard of hearing

2.6.7 Persons who are blind, deaf-blind, and visually impaired

2.6.8 Persons who are involved with the Department of Mental Health (DMH)

2.6.9 Youth and families involved with the Department of Children and Families (DCF)

2.6.10 Youth and families involved with the Department of Youth Services (DYS) and/or the juvenile court system

2.6.11 Youth who are on the Autism Spectrum

2.6.12 Persons who are receiving services from Department of Developmental Disabilities (DDS)

2.7 Intersystem planning and affiliation

2.7.1 Describe your organization's experience in convening a collaborative structure to integrate services across agencies.

2.7.2 Describe what processes and structures you would utilize to collaborate with other stakeholders in implementing, monitoring, and overseeing the performance of your ESP program. For example, would you establish a community advisory board, utilize a specific existing forum for obtaining feedback and recommendations about the functioning of your ESP, etc.?

2.8 Please describe how your organization shall train, develop, support, and evaluate all ESP staff individually and your ESP program as a whole, both initially and on an ongoing basis, to ensure that the core competencies described in 2.1 – 2.7 are consistently implemented in all ESP service components.

3. ESP service components: ***(100 points)***

3.1 Emergency Services Program (ESP): overall program

3.1.1 Provide a brief program description that summarizes your overall ESP program model addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

How shall you change the perception which may exist in your organization and/or in your community that the ESP's function is to conduct "hospital screening"? What operational and cultural changes shall your organization make to ensure the delivery of ESP services that consist of a comprehensive and discrete level of care, incorporating crisis assessment, resolution-focused intervention, and stabilization?

3.1.3 Describe how you shall realize the vision and manage your ESP program, inclusive of all service components, as one integrated continuum of emergency services responsible for meeting the emergency behavioral health needs throughout the proposed catchment areas.

3.1.4 Describe how your ESP program shall operate in a fashion that ensures fluidity among its service components, including how you shall use your staff resources in an integrated and flexible manner, while accommodating fluctuations in volume, location of services, etc. Please include your strategy to address seasonal variations in volume as well as variability among shifts.

3.1.5 Describe how your ESP's 800# and triage function shall operate, noting any variance by time of day or day of week.

3.1.6 Describe how you shall cover the entire geography in the proposed catchment area 24/7/365. Does your organization have resources, such as various locations you can leverage, as part of your strategy?

3.1.6.1 How shall you ensure a one-hour response time, from the time of readiness for ESP intervention, throughout the proposed catchment area 24/7/365? Do you anticipate any particular challenges with meeting this requirement in any areas within that catchment area, and if so, how shall you mitigate those challenges?

3.1.7 While a goal of this procurement is to ensure that the implementation of the ESP model shall be substantially consistent statewide, describe and give a rationale for any variances in the service model described in this RFR that you think are indicated to accommodate local needs, preferences, and/or resources in the proposed catchment area. Include but do not limit your response to any variance from the requirements included in Section II.D.2 Community-based location, under "description."

3.1.8 Location of services:

3.1.8.1 Please provide general information about the planned location(s) of ESP functions and services as well as hours of operation:

Service component	**Address(es) where service will be delivered or dispatched from**	**Days/hours of operation**		**Other services at this location**
		Of the service component	**Of the physical site**	
ESP Management functions				
800# and triage		24/7/365		
Community-based location				
Mobile Crisis Intervention		24/7/365		
Adult Mobile Crisis Intervention		24/7/365		
Adult CCS		24/7/365	24/7/365	
RAP		4:30p-8a; 24 hours weekends and holidays		

3.1.8.2 If you intend to change locations or make substantive changes to any existing physical plants prior to service start date or within the first six months of operation, please describe those plans here.

3.1.9 ESP management

3.1.9.1 Please attach resumes, or if not yet hired, please describe hiring qualifications of the following positions:

3.1.9.1.1 ESP Director

3.1.9.1.2 Quality/Risk Management Director

3.1.9.1.3 Medical Director

3.1.9.2 Attach an organization chart that indicates where these and other key ESP staff shall sit within the organization at an administrative and supervisory level.

3.1.10 Psychiatry: Describe your plan for psychiatry staffing and ensuring that all performance specifications related to access to adult and child psychiatric consultation and direct services, in all ESP service components, are met 24/7/365.

3.1.11 Safety: Articulate specific strategies you plan to employ to assess, and mitigate risk during the provision of ESP services in the community-based location and adult CCS as well as through Mobile Crisis Intervention services.

3.2 Community-based location

3.2.1 Describe your ESP's proposed community-based location(s) including:

3.2.1.1 General description of the physical plant, include parking, signage, entryway, waiting areas, treatment areas, meeting space, and staff work areas

3.2.1.2 Data supporting the fact that the location is centrally located in a major population center within the catchment area

3.2.1.3 Rationale for how this location is "in the community" and shall be perceived as such by those who utilize ESP services

3.2.1.3.1 Optional attachment: letters of support endorsing the selected location

3.2.1.4 Proximity and access to public transportation

3.2.1.5 How you shall establish a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support

3.2.1.6 How you shall concurrently communicate that this is a setting to receive help for crisis behavioral health needs rather than for routine services or general support and socialization

3.2.2 Describe how you shall utilize your community-based location(s) to achieve the goals of ESP and this procurement, including:

3.2.2.1 How the selected community-based location shall support the goal of diverting behavioral health utilization from the hospital EDs in the proposed catchment area

3.2.3 Staffing

3.2.3.1 Describe how the staffing in your community-based location shall be used flexibly to meet the needs on a daily basis, including integration with the adult CCS.

3.2.3.2 Describe how you shall utilize Certified Peer Specialist staff in your ESP community-based location(s).

3.3 Adult Mobile Crisis Intervention

3.3.1 Provide a brief program description that summarizes your planned Adult Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

3.3.2 Describe how you shall utilize bachelor's level staff and/or Certified Peer Specialists to support the adults utilizing these services and to assist the master's level clinicians in providing ESP services to adults in a mobile capacity.

3.4 Adult Community Crisis Stabilization (CCS)

3.4.1 Provide a brief program description that summarizes your planned adult CCS addressing, at a minimum, program philosophy and culture, target population, staffing pattern, service delivery mode, and flow of services.

3.4.2 Physical plant

3.4.2.1 General description of the adult CCS's space, including treatment areas, living space, meeting space, staff work areas, and parking

3.4.2.2 How you shall establish a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support

3.4.3 State your plan related to co-location of the adult CCS with the ESP community-based location

3.4.3.1 Describe the co-located or shared space relative to proximity, flow, and any space that shall be shared for functions of both the ESP and adult CCS.

3.4.3.2 State whether co-location shall be in place at the implementation of the ESP contract.

3.4.3.3 If it will not, attach an implementation plan outlining how and when co-location shall be achieved within three months of the initiation of the contract. (Note that failure to achieve co-location within three months may result in termination of the contract.)

3.4.4 If a bidder wishes to propose changes to the required minimum CCS capacity allocated to each catchment area, please describe your recommendations and related justification, including how the bidder proposes to increase the CCS capacity within the cost projections for each catchment area.

3.4.5 What is your proposed communication plan between your adult CCS and your other ESP service components, particularly your ESP community-based location, for example, staffing, sharing resources, transfers, sharing clinical knowledge, risk management/safety planning, joint rounds, joint staff meetings, etc.?

3.4.6 Describe your planned approach to utilize the full clinical potential of the adult CCS outlined in this RFR and the performance specifications. Address how shall you educate stakeholders of the capacity and acuity level of the adult CCS and how shall you make consumers, families, and other stakeholders feel comfortable using the adult CCS to treat those who present with a higher level of acuity.

3.5 Mobile Crisis Intervention (MCI) Response Section
(Note: An incomplete or unsatisfactory response to this element could exclude a bidder's proposal from consideration.)

3.5.1 Statement of intention:

☐ The bidder intends to directly operate the Mobile Crisis Intervention component of the ESP and shall demonstrate competency in the section that follows.

☐ The ESP intends to enter into a subcontract arrangement with another entity that meets the requirements of subcontractors outlined in Section V.C. of this RFR. Enter the name of the agency (additional information will be requested in narrative response section 4.3. below). The competency of the proposed subcontractor agency is demonstrated in the section that follows.

3.5.2 Provide a rationale for your organization's decision reflected in question 3.3.1 above and a brief summary of how your proposed subcontractor meets the provider qualifications for providing the subcontracted service component

3.5.3 Further demonstrate your organization's (or proposed subcontractor's) readiness to provide Mobile Crisis Intervention by attaching the following documents (as many as are available and applicable to your organization) in order to demonstrate meeting the criteria delineated in Section V.B. of this RFR:

3.5.3.1 Documented experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis prevention, resolution-focused crisis intervention, parental engagement and support, and/or treatment services, such as contracts for the provision of such services at various levels of care, clinical tools used to deliver effective resolution-focused intervention in collaboration with children and families, and/or data reflecting the number of children and adolescents served in the past year

3.5.3.2 Evidence of knowledge, commitment, and experience implementing services to children, adolescents, and families consistent with *Systems*

of Care and *Wraparound* principles (refer to Section II.D of this RFR)

3.5.3.3 Evidence of competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services

3.5.3.4 Policies, procedures, and/or clinical protocols developed specifically for the provision of behavioral health services to youth and families, including treatment strategies that differ from the strategies used for adults and how long these policies and procedures have been in effect

3.5.3.5 Outcomes data, quality improvement processes, and satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families

3.5.3.6 Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels in providing behavioral health services to children, adolescents, and their families. Evidence may include accreditation reports that speak to your work with youth and families and in-service training schedules or curriculums addressing the assessment and treatment of youth and families.

3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention

3.5.3.7.1 Résumés from current staff member(s) in your organization at director-level positions and above who have five or more years of experience providing behavioral health services to youth and families and would be involved in your organization's provision of Mobile Crisis Intervention

3.5.3.7.2 Job descriptions of any identified staff members who would be staffing the Mobile Crisis Intervention service in any capacity, including the Mobile Crisis Intervention program manager, child psychiatric clinicians, child-trained supervisors, child-trained clinicians, paraprofessionals and/or family partners

3.5.3.8 Experience of integrating youth and family voice in organization governance. Evidence may include names and length of service of those currently on advisory boards.

3.5.3.9 Relationships with child- and family-focused community resources in the service area, including but not limited to, child-serving state agencies and social service providers, schools, residential programs, family and youth organizations, and pediatric primary care providers. Evidence may include demonstrated ability to coordinate care and treatment across providers and service agencies, affiliation agreements with such organizations, and/or one sample of meeting

minutes demonstrating integration with other organizations' focus on youth and family services.

3.5.3.10 Membership in child advocacy and/or child-focused trade organizations

3.5.4 Mobile Crisis Intervention

3.5.4.1 Provide a brief program description that summarizes your planned Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

Describe how you will provide a bi-disciplinary (clinician and family partner) intervention to engage and address the treatment needs of the child while also engaging, and supporting the experiences of the parent(s) whose child is in crisis.

3.5.4.2 Describe how you shall manage staff resources to meet the variance in the needs of families and therefore the fluctuations in the intensity and duration of this service.

3.5.4.3 Describe how you plan to ensure that following an MCI intervention, for a calendar period of up to 7 days, the MCI shall provide continued intervention with a goal of crisis resolution, support family-specific alternatives to out of home placement, collaborate with other system providers to assure coordination of care stabilization and follow-up services. Address how you shall manage staff resources to meet the variance in the needs of families and therefore the fluctuations in the intensity and duration of this service.

3.5.5 Describe how you shall establish linkages with other CBHI services including Intensive Care Coordination (ICC) as well as other child behavioral health services, and how you shall utilize these linkages to ensure care coordination, continuity of care, and diversions from inpatient psychiatric services and other out of home placement.

3.6 Runaway Assistance Program (RAP)

Describe how your ESP program shall operate a Mobile Crisis Intervention/Runaway Assistance Program ("MCI/RAP") 24/7/365 to youth between the ages of 6 to 18. Identify the manager as well as the number of on-call FTE separate from the MCI staffing dedicated to this program.

3.6.1. Describe your experience in collaborating with local police departments, court clinics and DCF relative to youth served by your agency.

4. Additional response requirements, if applicable to bidder (considered but not scored)

4.1 Hospitals as bidders

4.1.1 For hospitals that are bidding on an ESP contract, articulate how you are positioned to achieve the goals of ESP and this procurement, including

diversion from hospital EDs and establishing a robust community-based presence.

4.2 Bidders submitting responses for multiple catchment areas

4.2.1 If your organization is the successful bidder in more than one catchment area, describe how this outcome shall affect your vision and organization of your ESP program, your implementation plan, and your staffing pattern.

4.2.2 Describe the strengths you would realize through serving multiple catchment areas from a quality and community perspective, and the efficiencies you would achieve.

4.3 Subcontracts

4.3.1 For any ESP service component for which your organization plans to enter into subcontract arrangements with other provider organizations, detail:

4.3.1.1 The name of the subcontracting agency and main reasons for selecting this agency to perform the given ESP service component

4.3.1.2 The ESP service component(s) for which you plan to subcontract with that agency

4.3.1.3 Specifically if the subcontract will encompass the given service component for the entire catchment area and population, or if it is specifically for a specific population, geographic area within the catchment area (e.g. Designated ED), or other subset

4.3.2 Describe how your organization shall, as the contracted ESP provider, oversee, monitor, and hold the subcontracted provider(s) accountable for all aspects of service delivery, including clinical, quality, and administrative.

4.3.3 Given any planned subcontracts, summarize how your organization shall meet the requirement that you as the contracted ESP contract holder must propose a program model that ensures that your organization directly provides the majority of ESP services.

C. Technology Specifications and Response Requirements *(20 points)*

(Note: Please "cut and paste" any questions below into your response that lend themselves to doing so, such as 2.1, 3.1-3.8 and 4.1.)

1. *Technology Infrastructure: General*

Specifications

It will be important that ESPs have robust Information Technology (IT) infrastructure to ensure the efficient operations of all responsibilities and activities of the ESP, including: service delivery, flow of information, support of community-based interventions, record keeping, appointment scheduling, obtaining authorizations, data management and reporting, billing, and interface with the Virtual Gateway.

Response requirements

1.1 Please describe your organization's current IT infrastructure, including the following:

1.1.1 Staffing resources (number of IT staff, titles, and hours of availability of IT support)

1.1.2 Telephone (including availability of conference phones at your site)

1.1.3 Management information system hardware and software

1.1.3.1 Specify whether you have or shall establish LAN and/or WAN configuration and networking software.

1.2 Electronic medical record capacity

1.2.1 Describe your agency's information system with regard to collecting and tracking clinical data.

1.2.2 Describe your agency's ability to share this clinical data throughout your organization's system so clinicians have immediate access to clinical information

2. *Communications*

Specifications

MBHP is committed to ensuring that all providers have equipment, policies, and procedures in place to ensure timely communication in both crisis and routine situations. This is essential to service delivery effectiveness as well as safety. Bidders should note that cell phones have been budgeted for all master's level clinicians and bachelor's level staff who work in Adult or Mobile Crisis Intervention.

Response requirements

2.1 Please describe your communications by answering the following questions:

2.1.1 Percentage of ESP clinicians who shall have on-site and remote access to e-mail ____%

2.1.2 Percentage of ESP clinicians who shall have access to on site and remote access to voice mail ____%

2.1.3 Percentage of ESP clinicians who shall have cell phones with GPS ____%

2.1.4 Planned frequency of structured staff meetings with all ESP staff ____

21.5 Percentage of ESP clinicians who shall have laptops or equivalent devices to perform required functions remotely. ___%

2.2 Describe how your agency has put the above communication systems in place, including coordinating communication with MBHP. If your agency has no system currently in place, describe how you would put the above system in place, including implementation timeframes.

2.3 Identify the unique communications challenges you would expect in operating an ESP contract and the specific strategies you plan to implement to ensure timely and effective communication, to facilitate quality, service coordination, and safety.

3. Provider Information Systems

Specifications

ESP providers shall be expected to have the capacity to perform the following function, and to implement these functions, as of the implementation date:

- Electronic submission of claims – Please note that single-claim submissions require Internet Explorer 8 or better; batch (multiple) claim submissions require EDI software; requires Windows 2000 or Windows XP to run (earlier versions of Windows and Windows Vista are not compatible).

Electronic submission of encounter form data Electronic Funds Transfer (EFT)

Additional software specifications

Providers shall need Internet Explorer 8 or better, e-mail, and an office suite of applications to handle any documentation sent to them or required from them.

Hardware specifications

Providers shall need sufficient PCs to accommodate whatever number of staff they have who shall need PC access. Additionally, bidders should note that laptops have been budgeted for all MS clinicians and BS staff who work in Adult or Mobile Crisis Intervention.

Response requirements

3.1 Describe your Management Information Systems (MIS) hardware by answering all of the following questions:

3.2

Type (check)	*Number of*		*Identify all operating systems you use:*
Servers ❑			
PCs ❑			
MACs ❑			
WS ❑			
Laptops ❑			
Tablets ❑			
Other ❑			

3.3 Do you have enough PCs, laptops, and/or tablets to accommodate all staff that shall need to have computer access?

❑Yes ❑ No

3.3.1 Do the laptops you provide in the field have broadband access directly through a wireless connection, so staff are able to access to any web-based applications? ❑Yes ❑ No

If not, do you plan to provide this access? ❑Yes ❑ No

3.3 Do you have a hospital management system or an automated claims/billing system?

❑Yes ❑ No

- If yes, name of system:_____

_____

3.4 Do you have 24/7 broadband access? ❑ Yes ❑ No

- If yes, what is the maximum speed? _____

3.5 Do you have web access? ❑ Yes❑ No

- If no, would you acquire Internet access if required? ❑ Yes ❑ No

3.6 Do you currently submit claims electronically? ❑ Yes ❑ No

- If no, briefly describe your plans to do so within ninety (90) days of the contract award.

3.7 If your organization is currently a contracted ESP provider, do you currently submit encounter forms electronically? ❑ Yes ❑ No

- If no, briefly describe your plans to do so within ninety (90) days of the contract award.

3.8. Do you currently receive payments via Electronic Funds Transfer (EFT)? ❑ Yes ❑ No

- If no, briefly describe your plans to do so within ninety (90) days of the contract award.

4. Data and Information Management

4.1 For the following areas, please indicate whether your Management Information System (MIS) **is capable of producing** reports in each topic area. Then note whether your organization currently **uses** these reports for ongoing management and/or quality improvement purposes:

	MIS Capability	*Currently in Use*
Financial Reports	❑	❑
Utilization Reports	❑	❑
Clinician Profiling	❑	❑
Client Profiling	❑	❑
Quality Measurements	❑	❑
Statistical Analysis	❑	❑

4.2 **Required attachment:** Please submit up to three of your most useful examples of MIS reports pertaining to some of the above categories.

5. Encounter Forms

MBHP requires completion of daily Emergency Service Program (ESP) Encounter Forms for every individual served.

5.1 Describe how your organization shall ensure completion of these forms according to MBHP policies and procedures, including staff training and complete and timely electronic submission to MBHP.

5.2 Describe your organization's capacity and planned practices to produce and use Encounter Form data for tracking, reporting, and quality improvement purposes, including your ability to report daily, monthly, and annually on encounter data by population, location, clinician, disposition, service component, and/or other variables as identified or requested.

D. Fiscal Specifications and Response Requirements

(There are no points for the following questions, but the responses will be considered in the overall evaluation of the proposal. Information provided in this section could exclude your proposal from consideration.)

Specifications

MBHP will provide reimbursement for the following populations: The PCC plan, uninsured, DMH-only, Medicare-only and Health New England Be Healthy (HNE).

The MassHealth Health Plans listed below will provide reimbursement for services delivered to their Members.

- Boston Medical Center Health Plan (BMCHP)
- All CarePlus Plans
- Celticare
- Fallon Community Health Plan
- Health New England Be Health (HNE)
- Neighborhood Health Plan (NHP)
- All OneCare Plans
- Tufts Health Plan – Network Health

Volume History

- Volume data by catchment area may be found in Appendix IX "Volume Data for Two (2) Previous Years." This appendix lists volume data by age group, i.e., child/adolescent and adult.
- Volume data include utilizers from the other MassHealth Managed Care Entities (MCEs).
- Volume data do not include any commercial volume given that this population is not in the mandated scope of ESP services.

ESP contracts and rates

- ESP providers shall contract with MBHP for the provision of ESP services to the populations and payers included in the scope of ESP services.
- ESP providers shall be expected to accept reasonable rate offers and contract with the other MassHealth MCEs.
- ESP providers shall be encouraged to negotiate contracts and rates with commercial insurance providers whose members are outside the mandated or funded scope of ESP services delineated in Section II, but who may benefit from access to them, as long as the ESP is staffed adequately to ensure there is no disruption in delivery of services to contracted payer members.
- ESP services unbundled from ESP rates: for the following required services, ESP providers will be reimbursed through outpatient billing via their licensed outpatient mental health clinics rather than through ESP funding, rates, or billing:
  - Risk management/safety planning provided by the ESP without the need for crisis intervention, evaluation, or stabilization (i.e., before or to prevent the need for an ESP encounter)
  - Urgent psychopharmacology services (face to face) referred by ESP

Response requirements

1. *Fiscal year program budget response requirements*

1.1 Required attachment: submit a proposed program budget by completing the ESP Cost Report located in Appendix VIII, outlining program capacity, anticipated expenditures, and all funding sources. The ESP Cost Report was created to facilitate the collection of detailed provider information regarding the costs of providing ESP services and the volume of services being provided. This ESP Cost Report was developed based on the MH, PDT, and SA Supplemental Schedules from the MA Uniform Financial Report (UFR). The bidder should use the following data included in the appendices in designing their program models and developing their program budgets: projected cost by catchment area, volume history by catchment area, and core staffing pattern.

- When completing the required ESP Cost Report, the bidder must include all anticipated expenditures and revenue including any projected offsets.

- The bidder must detail the number of FTEs associated with each payroll line item.
- The bidder should utilize Appendix IV (Core Staffing Patterns) and Appendix V (Minimum and Suggested Compensation Levels) as guidelines in designing their staffing patterns and related budgets to meet the needs of the proposed catchment area. This appendix represents a recommended staffing pattern for an average size ESP to carry out the program model described in this RFR. It also informs the bidder about key aspects of the methodology on which the cost projections have been based. Providers will retain control over their business practices, such as salary levels.

2. Budget narrative response requirements

2.1 Submit a budget narrative that further defines and explains the program budget that is submitted via the ESP Cost Report found in Appendix VIII. The budget narrative provides the bidder with an opportunity to highlight what is unique or different about their program and corresponding cost report.

The narrative must include the following:

- The source of any projected offsets, methodology for arriving at offsetting revenue projections, how and when projected offsets will be collected, and how they will benefit the program
- How revenues will be billed and collected from MBHP, Medicaid Fee-for-Service, and other insurance that are anticipated to be billed to these entities
- The number of hours considered Full-Time Equivalent (for example, 35, 37.5, 40)
- Regarding the staffing pattern reflected in the ESP Cost Report, justification for any variance in the proposed staffing pattern and related expense as compared to the Core Staffing Pattern in Appendix IV.

3. Business component response requirements

MBHP is committed to ensuring that ESP providers are financially viable. Financial viability is defined as the ability to adequately support the specific operations of each service or program that is under consideration for contracting for the full duration of the contract.

3.1 Audited financial statements

- Required attachment: independently audited financial statements for the two most recent fiscal years
- Narrative: Briefly address any qualified opinions contained in the audited financial statements.

3.2 Pre-Qualification Required attachment, if applicable: If your organization is required to complete a Pre-Qualification package as specified by EOHHS attach documentation that you have achieved pre-qualified or qualified financial status from the EOHHS for this fiscal year.

- Narrative: Briefly address any reasons for not attaining pre-qualified or qualified status and for any corrective action plans that may be underway.

3.3 Working capital

- Required attachment: documentation that demonstrates sufficient working capital to support three months of operating expenses. For this application, capital is defined as: bank lines of credit, equity holdings or contributions, and cash on hand.
- Narrative: Briefly qualify or describe the bidder's status relative to working capital.

3.4 Accounts payable

- Required attachment: documentation that identifies the bidder's history of accounts payable turnaround time
- Narrative: Briefly qualify or describe the bidder's status relative to accounts payable.

3.5 Accounts receivable

- Required attachment: documentation that describes the history of accounts receivable days outstanding
- Narrative: Briefly qualify or describe the bidder's status relative to accounts receivable.

3.6 Government action

- Required attachment, if applicable: documentation that addresses their current and recent historical data (five most recent fiscal years) pertaining to state or federal government held liens due to failure to pay payroll tax liabilities
- Narrative: Briefly qualify or describe any government action taken.

3.7 Other corrective actions or sanctions

- Narrative, if applicable: If your organization has been placed on any other corrective action plan or has had any other sanctions imposed by any state or federal agency or managed care company in the past five years, please indicate the nature of the corrective action, the steps your organization has taken to ameliorate the situation, and the current status.

3.8 Payroll obligations

- Required attachment: documentation that addresses the bidder's ability to meet payroll obligations on time during the previous three years
- Narrative: Briefly qualify or describe the bidder's ability to meet payroll obligations.

3.9 Insurance coverage

- Required attachments: documentation of malpractice insurance coverage for the organization and a comprehensive general liability policy with respect to the proposed location and worker's compensation insurance covering bidder's employees.

- Narrative: Briefly qualify or describe the bidder's status relative to malpractice insurance coverage.

3.10 Privatization Law Assurances

- Required attachment: review and sign the form contained in Appendix X acknowledging your organization's commitment to implementing the privatization requirements outlined in M.G.L. c. 7 §§ 52, 53, 54, and 55.

DMH Southeast Emergency Services Program Privatization Analysis

Cost Forms

Form 1. Cost Comparison

APPENDIX C (Form 1)

Cost Comparison Form

A. In-House Cost Estimate (Avoidable Costs from Form 2)	$ 13,024,296
B. Contract Performance Costs (From Form 3)	$ 6,631,329
C. Cost Savings	$ 6,392,967

Cost Comparison Decision — Approved by:

In-House _____ Signature _____ Date 12/29/2015

Form 2 In-House Cost Estimate

APPENDIX C (Form 2)

In-House Cost Estimate

FULLY ALLOCATED COST

	Fiscal Year 2016	Avoidable Cost	Avoidable Costs*	Fiscal Year 2017	Avoidable Cost	Avoidable Costs*	Fiscal Year 2018	Avoidable Cost	Avoidable Cost*	Total	Avoidable Cost	Avoidable Cost*
Direct Costs												
Personnel Cost	$ 12,559,850	$ 12,559,850	$ 11,817,338	$ 12,945,388	$ 12,945,388	$ 11,430,291	$ 13,339,071	$ 13,339,071	$ 11,343,342	$ 38,844,309	$ 38,844,309	$ 34,590,971
Material and Supply Costs	$ 6,662	$ 6,662	$ 6,662	$ 6,866	$ 6,866	$ 6,866	$ 7,075	$ 7,075	$ 7,075	$ 20,602	$ 20,602	$ 20,602
Other Direct Costs												
Rent	$ -	$ -	$ -	$ 186,573	$ 186,573	$ 186,573	$ 154,838	$ 154,838	$ 154,838	$ 341,411	$ 341,411	$ 341,411
Depreciation	$ 66,732	$ 61,552	$ 61,552	$ 68,781	$ 63,441	$ 68,781	$ 70,872	$ 65,371	$ 70,872	$ 206,385	$ 190,364	$ 201,205
Maintenance	$ 230,767	$ 211,517	$ 211,517	$ 237,850	$ 218,010	$ 237,850	$ 245,084	$ 224,640	$ 245,084	$ 713,701	$ 654,166	$ 694,451
Utilities	$ 426,404	$ 394,707	$ 394,707	$ 439,493	$ 406,823	$ 439,493	$ 452,858	$ 419,194	$ 452,858	$ 1,318,755	$ 1,220,724	$ 1,287,058
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ 4,636,959	$ 4,590,514	$ 4,606,697	$ 4,779,295	$ 4,731,425	$ 4,814,771	$ 4,924,639	$ 4,875,313	$ 5,027,859	$ 14,340,893	$ 14,197,252	$ 14,449,327
			$ -									
Indirect Costs			$ -									
Departmental	$ 880,045	$ -	$ -	$ 907,059	$ -	$ -	$ 934,644	$ -	$ -	$ 2,721,748	$ -	$ -
Executive Office	$ 280,168	$ -	$ -	$ 288,768	$ -	$ -	$ 297,550	$ -	$ -	$ 866,486	$ -	$ -
Central Services	$ 107,134	$ -	$ -	$ 110,422	$ -	$ -	$ 113,780	$ -	$ -	$ 331,336	$ -	$ -
Total In-House Costs	**$ 19,194,720**	**$ 17,824,801**	**$ 17,098,472**	**$ 19,970,495**	**$ 18,558,525**	**$ 17,184,625**	**$ 20,540,411**	**$ 19,085,501**	**$ 17,301,928**	**$ 59,705,626**	**$ 55,468,828**	**$ 51,585,025**
Less Total Revenue	$ 4,038,288	$ 4,038,288	$ 4,074,176	$ 4,162,247	$ 4,162,247	$ 4,257,838	$ 4,288,826	$ 4,288,826	$ 4,482,399	$ 12,489,360	$ 12,489,360	$ 12,814,413
Total Costs	**$ 15,156,432**	**$ 13,786,514**	**$ 13,024,296**	**$ 15,808,248**	**$ 14,396,278**	**$ 12,926,787**	**$ 16,251,585**	**$ 14,796,676**	**$ 12,819,529**	**$ 47,216,265**	**$ 42,979,468**	**$ 38,770,612**

*Denotes Management Study savings calculations included

Form 2A Summary In-House Cost Estimate

APPENDIX C (Form 2a)

Summary In-House Cost Estimate

	Current Operating Budget	Cost Adjustment Factor	Revised Total Cost Fiscal Year 2016	Revised Total Cost Fiscal Year 2016*	Cost Adjustment Factor	Revised Total Cost Fiscal Year 2017	Revised Total Cost Fiscal Year 2017*	Cost Adjustment Factor	Revised Total Cost Fiscal Year 2018	Revised Total Cost Fiscal Year 2018*
Direct Cost		**2.91%**			**3.07%**			**3.04%**		
Personnel Wages										
Administrative Assistant I	$70,283	$2,048	$72,331	$72,331	$2,220	$74,551	$74,551	$2,267	$76,818	$76,818
Clerk III	$49,177	$1,433	$50,610	$50,610	$1,554	$52,163	$52,163	$1,586	$53,750	$53,750
Clinical Social Worker (A/B)	$1,436,296	$41,859	$1,478,155	$1,395,941	$45,374	$1,523,528	$1,099,840	$46,332	$1,569,861	$963,858
Clinical Social Worker (C)	$747,949	$21,798	$769,747	$941,064	$23,628	$793,375	$969,951	$24,127	$817,502	$999,448
Clinical Social Worker (D)	$754,822	$21,998	$776,820	$638,234	$23,845	$800,665	$657,825	$24,349	$825,014	$677,830
Community Psychiatric Mh Nurse	$146,322	$4,264	$150,586	$150,586	$4,622	$155,209	$155,209	$4,720	$159,929	$159,929
Human Services Coordinator (A/B)	$90,614	$2,641	$93,255	$93,255	$2,863	$96,117	$96,117	$2,923	$99,040	$99,040
Human Services Coordinator (C)	$3,743,389	$109,095	$3,852,484	$3,252,499	$118,256	$3,970,741	$3,013,387	$120,754	$4,091,495	$2,850,884
Human Services Coordinator (D)	$246,056	$7,171	$253,227	$243,250	$7,773	$261,000	$250,716	$7,937	$268,937	$258,341
Licensed Practical Nurse I	$403,203	$11,751	$414,954	$414,954	$12,737	$427,692	$427,692	$13,007	$440,698	$440,698
Licensed Practical Nurse II	$601,443	$17,528	$618,971	$798,623	$19,000	$637,971	$1,011,821	$19,401	$657,372	$1,156,294
Mental Health Coordinator I	$1,254,886	$36,572	$1,291,458	$1,291,458	$39,643	$1,331,101	$1,331,101	$40,480	$1,371,581	$1,371,581
Mental Health Worker I	$396,694	$11,561	$408,256	$408,256	$12,532	$420,787	$420,787	$12,797	$433,584	$433,584
Mental Health Worker II	$296,811	$8,650	$305,462	$305,462	$9,376	$314,838	$314,838	$9,575	$324,413	$324,413
Psychologist IV	$356,829	$10,399	$367,228	$327,527	$11,272	$378,500	$337,581	$11,511	$390,011	$347,847
Registered Nurse II	$1,132,565	$33,007	$1,165,572	$942,554	$35,778	$1,201,350	$710,913	$36,534	$1,237,885	$607,845
Registered Nurse IV	$258,262	$7,527	$265,788	$265,788	$8,159	$273,947	$273,947	$8,331	$282,278	$282,278
Registered Nurse V	$161,093	$4,695	$165,788	$165,788	$5,089	$170,877	$170,877	$5,197	$176,074	$176,074
Social Worker (C)	$57,484	$1,675	$59,159	$59,159	$1,816	$60,975	$60,975	$1,854	$62,830	$62,830
Materials & Supplies										
Office Supplies	$5,667	$165	$5,832	$5,832	$179	$6,012	$6,012	$183	$6,194	$6,194
Equipment Purchase	$806	$23	$829	$829	$25	$854	$854	$26	$880	$880
Other Direct Costs										
Travel and Other Employee Reimb.	$113,926	$3,320	$117,247	$66,762	$3,599	$120,846	$68,811	$3,675	$124,521	$70,904
Payroll Taxes	$155,565	$4,534	$160,099	$160,099	$4,914	$165,013	$165,013	$5,018	$170,031	$170,031
Office Equipment Lease	$5,210	$152	$5,362	$5,362	$165	$5,527	$5,527	$168	$5,695	$5,695
Depreciation	$64,842	$1,890	$66,732	$66,732	$2,048	$68,781	$68,781	$2,092	$70,872	$70,872
Administration	$827,535	$24,117	$851,652	$918,320	$26,142	$877,795	$1,013,175	$26,695	$904,489	$1,110,653
Plant Maintenance	$224,232	$6,535	$230,767	$230,767	$7,084	$237,850	$237,850	$7,233	$245,084	$245,084
Plant Operations	$414,329	$12,075	$426,404	$426,404	$13,089	$439,493	$439,493	$13,365	$452,858	$452,858
Housekeeping	$131,498	$3,832	$135,330	$135,330	$4,154	$139,485	$139,485	$4,242	$143,726	$143,726
Subcontracted Direct Care	$931,712	$27,153	$958,865	$958,865	$29,433	$988,299	$988,299	$30,055	$1,018,354	$1,018,354
Medical Records	$362,411	$10,562	$372,973	$372,973	$11,449	$384,422	$384,422	$11,691	$396,112	$396,112
Contracted Observation Beds	$890,742	$25,959	$916,701	$916,701	$28,139	$944,840	$944,840	$28,734	$973,574	$973,574
Medical Staff	$1,066,631	$31,085	$1,097,716	$1,097,716	$33,696	$1,131,412	$1,131,412	$34,407	$1,165,819	$1,165,819
Leased Equipment	$20,418	$595	$21,013	$21,013	$645	$21,658	$21,658	$659	$22,317	$22,317
Total Direct Costs	**$17,419,702**	**$507,671**	**$17,927,373**	**$17,201,044**	**$550,300**	**$18,477,673**	**$17,045,922**	**$561,926**	**$19,039,599**	**$17,196,416**
Indirect Costs										
Departmental	$855,124	$24,921	$880,045	$880,045	$27,014	$907,059	$907,059	$27,585	$934,644	$934,644
Executive Office	$272,234	$7,934	$280,168	$280,168	$8,600	$288,768	$288,768	$8,782	$297,550	$297,550
Central Services	$104,100	$3,034	$107,134	$107,134	$3,289	$110,422	$110,422	$3,358	$113,780	$113,780
Total Indirect Costs	**$1,231,458**	**$35,889**	**$1,267,347**	**$1,267,347**	**$38,903**	**$1,306,249**	**$1,306,249**	**$39,724**	**$1,345,974**	**$1,345,974**
Total Direct & Indirect Costs	**$18,651,160**	**$543,560**	**$19,194,720**	**$18,468,391**	**$589,202**	**$19,783,922**	**$18,352,171**	**$601,650**	**$20,385,573**	**$18,542,390**
Less Total Revenue	$3,923,931	$114,357	$4,038,288	$4,074,176	$123,960	$4,162,247	$4,257,838	$126,578	$4,288,826	$4,482,399
Total Costs	**$14,727,229**	**$429,203**	**$15,156,432**	**$14,394,215**	**$465,243**	**$15,621,675**	**$14,094,333**	**$475,072**	**$16,096,747**	**$14,059,990**

*Denotes Management Study saving calculations included

Form 2B Personnel Cost Worksheet

APPENDIX C (Form 2b)

Personnel Cost Worksheet

					Payroll Tax Rate FY15	1.59%
					Fringe Rate FY15	27.27%
Position Title or Skill	**FTEs Required**	**Annual Wage**	**Other Pay**	**Basic Pay**	**Fringe Benefits**	**Personnel Cost**
Administrative Assistant I	1.00	$55,223	$0	$55,223	$15,059	$70,283
Clerk III	1.00	$38,640	$0	$38,640	$10,537	$49,177
Clinical Social Worker (A/B)	15.90	$1,120,168	$20,258	$1,140,425	$295,871	$1,436,296
Clinical Social Worker (C)	6.75	$598,013	$5,575	$603,589	$144,360	$747,949
Clinical Social Worker (D)	6.00	$625,739	$162	$625,901	$128,921	$754,822
Community Psychiatric Mh I	1.00	$112,682	$4,327	$117,009	$29,313	$146,322
Human Services Coordinato	1.00	$72,171	$216	$72,388	$18,226	$90,614
Human Services Coordinato	39.50	$2,927,947	$71,645	$2,999,592	$743,797	$3,743,389
Human Services Coordinato	2.50	$194,172	$6,824	$200,996	$45,060	$246,056
Licensed Practical Nurse I	4.80	$314,231	$8,914	$323,144	$80,059	$403,203
Licensed Practical Nurse II	8.00	$462,542	$15,091	$477,632	$123,810	$601,443
Mental Health Coordinator I	19.40	$977,976	$19,364	$997,340	$257,546	$1,254,886
Mental Health Worker I	8.00	$299,370	$15,963	$315,332	$81,362	$396,694
Mental Health Worker II	5.00	$235,665	$6,807	$242,472	$54,340	$296,811
Psychologist IV	2.00	$288,215	$928	$289,143	$67,686	$356,829
Registered Nurse II	8.80	$871,498	$33,072	$904,570	$227,995	$1,132,565
Registered Nurse IV	2.00	$203,578	$1,235	$204,813	$53,449	$258,262
Registered Nurse V	1.00	$129,661	$650	$130,311	$30,782	$161,093
Social Worker (C)	0.60	$43,641	$1,800	$45,442	$12,042	$57,484
	134.25	**$9,571,132**	**$212,831**	**$9,783,963**	**$2,420,214**	**$12,204,177**

Description

a. **Position Title or Skill:** Example: carpenter, driver, janitor, supervisor, administrative clerk.
b. **FTEs Required:** Show the number of full time equivalent (FTE) positions required for each grade.
c. **Annual Salary/Wages:** Use current pay rates and multiply the pay rates by the number of FTEs.
d. **Other Pay:** Includes pay that will also earn fringe benefits, e.g., night differential pay, premium pay for firefighters and law enforcement officers.
e. **Basic Pay:** Salary/wages plus other pay.
f. **Fringe Benefits:** Multiply Basic Pay by the statewide percentage factor for fringe benefits.
g. **Personnel Cost:** Add Basic Pay and Fringe Benefits for all positions.

DMH Southeast Emergency Services Program Privatization Analysis

Form 3 Contract Performance Costs

APPENDIX C (Form 3)

Contract Performance Costs

	Amount
1. Contract Price	$ 5,617,171
2. Contract Administration	$ -
3. Transition Costs	$ 1,014,158
Unemployment benefits	$ 954,158
Retirement benefits	
Other transition costs (one time start up payment)	$ 60,000
Gain or loss on disposal of assets	
Other revenue (deduct)*	
Savings (deduct)	
4. Lost Tax Revenue	$ -
5. State Income Tax (Deduct)	$ -
Total Contract Costs	$ 6,631,329

	Signature	Title	Date
Prepared By	Stephen Barnard	CFO	12/29/15
Approved By (Head of Agency)	John Michael Cannavone		12/29/15

*As reflected in the supporting documents, the Contract Price reflects the increase in the PMPM (per member per month) rate that MassHealth will pay to its contracted MCO's for the provision of ESP services in the Southeast Area as well as the cost to DMH to reimburse MassHealth for services provided to the uninsured, and additional costs borne by Masshealth for the "Fee for Service" population (those covered by third party payors, such as Medicare or private insurance). DMH expects that the increase in the PMPM will also result in an increase in federal reimbursement to the Commonwealth, equal to an estimated 50% of the costs associated with the PMPM rate increase (i.e., 50% of $3.4 million, or up to $1.7 million per year). This will result in increased savings to the Commonwealth (in the "Other revenue" category). While these federal reimbursements were included in the calculation of revenues in Forms 2 and 2a (in-house costs), they are not included in the Contract Price as a conservative measure, since the entire amount must be paid initially from Commonwealth funds.

Supporting Documentation

Financial Notes Overview

The following financial notes have been drafted to provide specific insights related to the completion of Forms One, Two, and Three which are aggregations of costs incurred by the Commonwealth through the operations of four emergency service program based in:

- Brockton, MA at the Brockton Multi Service Center (pages 539 – 573);
- Norton, MA at the Taunton / Attleboro Emergency Service Location (included in Brockton notes);
- Fall River, MA at the Corrigan Mental Health Center (pages 574 – 598). And
- Pocasset, MA as well as on Martha's Vineyard and Nantucket islands (collectively referred to as the "Cape and the Islands") (pages 599 – 628).

These forms have been prepared separately in accordance with the guidance provided in the Guidelines for Implementing the Privatization Law as published by the Office of the State Auditor in June 2012.

Form 1 Notes

The in-house cost estimate is the total avoidable costs calculated in Form 2 including all cost savings associated with the management study's conclusions.

Final costs savings as cited on row C on Form 1 is based on the first transition year following the proposed privatization.

Form 2 includes two separate expressions of the in-house cost estimates for each transition year. The first titled "Avoidable Costs" is based on total in-house costs, including avoidable costs only. The second column titled "Avoidable Cost*" includes avoidable costs while also considering all expense and revenue implications identified within the management study.

For year one, a total estimated management study savings of $904,120 was estimated, however $141,904 of this was attributed to the CCBC contract for Runaway Assistance Program services. These funds were not included in the initial in-house cost estimates, therefore they are not included in the difference between FY16 totals and the Avoidable Cost* totals for FY16. As a result the overall cost savings for year 1 appears as $762,216.

Form 2 Notes

Various data sources were used to complete all necessary accounting efforts in the development of Form Two. These sources primarily include previously certified and submitted Uniform Financial Reports (UFR) and the Medicaid 403 reports for each of the facilities included in this privatization study.

Additional internal DMH personnel data was also considered. These exact data sources have been cited as applicable throughout the following financial notes.

All current budget year data is based on FY14 information with the exception of certain salary data which were based on point in time estimates taken at the end of CY14 (December 31st, 2014). The ESP program uses a number of sub-unit codes for cost tracking purposes; these codes are referenced throughout these financial notes and are derived from the DMH chart of accounts.[1]

All expenses incurred in Form 2 are categorized as either avoidable or unavoidable. Under direct costs, all personnel costs incurred have been classified as avoidable under the privatization effort. Additionally, material and supply costs will be avoidable as these expenses are tied directly to the services currently provided in-house.

DMH was anticipating moving their Pocasset facility to a more central location in Hyannis. Through preliminary efforts to identify these anticipated costs, DMH received two bids from prospective locations (totaling $135,920/ year and $169,226 / year). The average of these two estimates per year were included as likely rent expenses in FY 17 and FY18. The proposed relocation would also require an estimated additional $34,000 in likely moving expenses. This was included as one-time FY17 cost bringing the total expense for FY17 to $186,573. This contract can be found in exhibit 22 on page 626.

All directly attributed depreciation, administration, plant maintenance, plant operations and housekeeping costs are categorized primarily as avoidable cost. However, it was assumed that 10% of all of these direct costs for the BMSC should be considered unavoidable as this facility is currently owned by the Commonwealth of Massachusetts and thus would not be closed entirely under a privatization effort.

In the category of other costs, avoidable costs included travel and other employee reimbursement and payroll taxes. Office equipment leases were determined to be avoidable so long as DMH were to act in good faith by giving proper notice to building owners in advance of the termination of leases.

Finally, subcontracted direct care, medical records, contracted observation beds, medical staff and leased equipment are 100% avoidable as all costs are tied specifically to the direct provisioning of services provided.

Total revenue at each ESP facility was incorporated into the cost forms to determine an accurate calculation of the operating profit/loss in total for the four SE ESP locations. Total revenues for each facility were pulled from the document titled FY14 Revenue by Payer (included in exhibits below).

[1] http://www.mass.gov/osc/docs/close-open/co-expenditure-classification-handbook.doc

Brockton Multi Service Center (BMSC) Emergency Services Program (ESP) Cost Forms

APPENDIX C (Form 2)

In-House Cost Estimate

FULLY ALLOCATED COST

	Fiscal Year 2016	Avoidable Cost	Fiscal Year 2017	Avoidable Cost	Fiscal Year 2018	Avoidable Cost	Total	Total Avoidable Cost
Direct Cost								
Personnel Cost	$ 7,210,992.34	$ 7,210,992.34	$ 7,432,341.44	$ 7,432,341.44	$ 7,658,366.92	$ 7,658,366.92	$ 22,301,700.70	$ 22,301,700.70
Material and Supply Costs	$ 4,495.48	$ 4,495.48	$ 4,633.48	$ 4,633.48	$ 4,774.39	$ 4,774.39	$ 13,903.35	$ 13,903.35
Other Direct Costs								
Rent	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Depreciation	$ 51,802.30	$ 46,622.07	$ 53,392.43	$ 48,053.18	$ 55,016.15	$ 49,514.53	$ 160,210.87	$ 144,189.79
Maintenance	$ 192,498.76	$ 173,248.88	$ 198,407.71	$ 178,566.94	$ 204,441.50	$ 183,997.35	$ 595,347.97	$ 535,813.17
Utilities	$ 316,972.58	$ 285,275.32	$ 326,702.39	$ 294,032.15	$ 336,637.76	$ 302,973.98	$ 980,312.73	$ 882,281.45
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ 1,732,319.94	$ 1,685,875.35	$ 1,785,495.35	$ 1,737,625.09	$ 1,839,794.18	$ 1,790,468.14	$ 5,357,609.48	$ 5,213,968.58
Indirect Costs								
Departmental	$ 579,908.31	$ -	$ 597,709.22	$ -	$ 615,886.20	$ -	$ 1,793,503.73	$ -
Executive Office	$ 179,977.37	$ -	$ 185,501.97	$ -	$ 191,143.28	$ -	$ 556,622.62	$ -
Central Services	$ 69,689.50	$ -	$ 71,828.69	$ -	$ 74,013.08	$ -	$ 215,531.26	$ -
Total In-House Costs	**$ 10,338,656.58**	**$ 9,406,509.45**	**$ 10,656,012.67**	**$ 9,695,252.28**	**$ 10,980,073.45**	**$ 9,990,095.31**	**$ 31,974,742.70**	$ 29,091,857.04
Less Total Revenue	$ 3,045,611.62	$ 3,045,611.62	$ 3,139,099.92	$ 3,139,099.92	$ 3,234,563.32	$ 3,234,563.32	$ 9,419,274.86	$ 9,419,274.86
Total Costs	$ 7,293,044.96	$ 6,360,897.82	$ 7,516,912.75	$ 6,556,152.36	$ 7,745,510.14	$ 6,755,531.99	$ 22,555,467.85	$ 19,672,582.18

APPENDIX C (Form 2a)

Summary In-House Cost Estimate

	Current Operating Budget	Adjustments	Revised Total Cost Period A	Adjustments	Revised Total Cost Period B	Adjustments	Revised Total Cost Period C
Direct Cost							
		2.91%		3.07%		3.04%	
Personnel Wages							
Administrative Assistant I	$70,282.59	$2,048.28	$72,330.87	$2,220.27	$74,551.15	$2,267.18	$76,818.33
Clinical Social Worker (A/B)	$982,372.34	$28,629.76	$1,011,002.10	$31,033.79	$1,042,035.88	$31,689.43	$1,073,725.31
Clinical Social Worker (C)	$446,660.41	$13,017.24	$459,677.66	$14,110.30	$473,787.95	$14,408.40	$488,196.35
Clinical Social Worker (D)	$420,379.15	$12,251.32	$432,630.47	$13,280.05	$445,910.52	$13,560.62	$459,471.14
Community Psychiatric Mh Nurse	$146,321.86	$4,264.33	$150,586.19	$4,622.40	$155,208.60	$4,720.06	$159,928.66
Human Services Coordinator (A/B)	$90,614.09	$2,640.81	$93,254.90	$2,862.56	$96,117.46	$2,923.04	$99,040.50
Human Services Coordinator (C)	$1,467,664.27	$42,772.86	$1,510,437.13	$46,364.48	$1,556,801.61	$47,344.01	$1,604,145.62
Licensed Practical Nurse II	$525,001.35	$15,300.37	$540,301.72	$16,585.14	$556,886.86	$16,935.53	$573,822.39
Mental Health Coordinator I	$685,768.34	$19,985.68	$705,754.03	$21,663.87	$727,417.90	$22,121.56	$749,539.46
Mental Health Worker I	$267,919.64	$7,808.11	$275,727.76	$8,463.76	$284,191.52	$8,642.57	$292,834.09
Mental Health Worker II	$296,811.41	$8,650.12	$305,461.53	$9,376.47	$314,838.00	$9,574.56	$324,412.56
Psychologist IV	$199,468.25	$5,813.20	$205,281.45	$6,301.33	$211,582.79	$6,434.46	$218,017.25
Registered Nurse II	$1,132,564.96	$33,006.90	$1,165,571.86	$35,778.47	$1,201,350.33	$36,534.35	$1,237,884.69
Registered Nurse IV	$113,868.11	$3,318.51	$117,186.62	$3,597.17	$120,783.79	$3,673.16	$124,456.95
Registered Nurse V	$161,093.22	$4,694.82	$165,788.04	$5,089.04	$170,877.08	$5,196.56	$176,073.64
Materials & Supplies							
Office Supplies	$4,368.18	$127.30	$4,495.48	$137.99	$4,633.48	$140.91	$4,774.39
Equipment Purchase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Direct Costs							
Travel and Other Employee Reimb.	$45,932.25	$1,338.63	$47,270.88	$1,451.03	$48,721.91	$1,481.69	$50,203.59
Payroll Taxes	$89,447.75	$2,606.82	$92,054.57	$2,825.71	$94,880.29	$2,885.41	$97,765.70
Office Equipment Lease	$3,724.44	$108.54	$3,832.98	$117.66	$3,950.64	$120.14	$4,070.78
Depreciation	$50,335.35	$1,466.95	$51,802.30	$1,590.13	$53,392.43	$1,623.72	$55,016.15
Administration	$368,474.50	$10,738.63	$379,213.13	$11,640.35	$390,853.48	$11,886.27	$402,739.76
Plant Maintenance	$187,047.54	$5,451.22	$192,498.76	$5,908.95	$198,407.71	$6,033.79	$204,441.50
Plant Operations	$307,996.48	$8,976.09	$316,972.58	$9,729.81	$326,702.39	$9,935.37	$336,637.76
Housekeeping	$82,819.17	$2,413.64	$85,232.81	$2,616.31	$87,849.13	$2,671.59	$90,520.71
Subcontracted Direct Care	$931,712.01	$27,153.34	$958,865.35	$29,433.39	$988,298.74	$30,055.23	$1,018,353.97
Medical Records	$140,735.51	$4,101.52	$144,837.03	$4,445.93	$149,282.96	$4,539.86	$153,822.81
Leased Equipment	$20,418.13	$595.06	$21,013.19	$645.02	$21,658.21	$658.65	$22,316.86
Total Direct Costs	$9,239,801.32	$269,280.08	$9,509,081.40	$291,891.39	$9,800,972.79	$298,058.11	$10,099,030.90
Indirect Costs							
Departmental	$563,486.35	$16,421.96	$579,908.31	$17,800.90	$597,709.22	$18,176.98	$615,886.20
Executive Office	$174,880.73	$5,096.64	$179,977.37	$5,524.60	$185,501.97	$5,641.31	$191,143.28
Central Services	$67,716.02	$1,973.48	$69,689.50	$2,139.19	$71,828.69	$2,184.39	$74,013.08
Total Indirect Costs	$806,083.10	$23,492.08	$829,575.18	$25,464.69	$855,039.87	$26,002.68	$881,042.55
Total Direct & Indirect Costs	$10,045,884.42	$292,772.16	$10,338,656.58	$317,356.08	$10,656,012.67	$324,060.79	$10,980,073.45
Less Total Revenue	$2,959,365.38	$86,246.24	$3,045,611.62	$93,488.29	$3,139,099.92	$95,463.40	$3,234,563.32
Total Costs	$7,086,519.04	$206,525.92	$7,293,044.96	$223,867.79	$7,516,912.75	$228,597.39	$7,745,510.14

APPENDIX C (Form 2b)

Personnel Cost Worksheet

Position Title or Skill	FTEs Required	Annual Wage	Other Pay	Basic Pay	Fringe Benefits	Personnel Cost
Administrative Assistant I	1.00	$ 55,223.22	$ -	$ 55,223.22	$ 15,059.37	$ 70,282.59
Clinical Social Worker (A/B)	11.00	$ 764,016.22	$ 16,293.42	$ 780,309.65	$ 202,062.69	$ 982,372.34
Clinical Social Worker (C)	3.75	$ 361,382.81	$ 2,977.04	$ 364,359.84	$ 82,300.57	$ 446,660.41
Clinical Social Worker (D)	3.00	$ 353,013.01	$ 54.78	$ 353,067.79	$ 67,311.36	$ 420,379.15
Community Psychiatric Mh Nurse	1.00	$ 112,682.09	$ 4,327.18	$ 117,009.27	$ 29,312.59	$ 146,321.86
Human Services Coordinator (A/B)	1.00	$ 72,171.13	$ 216.47	$ 72,387.60	$ 18,226.49	$ 90,614.09
Human Services Coordinator (C)	15.60	$ 1,150,770.02	$ 23,230.92	$ 1,174,000.94	$ 293,663.33	$ 1,467,664.27
Licensed Practical Nurse II	7.00	$ 402,158.39	$ 15,113.03	$ 417,271.42	$ 107,729.93	$ 525,001.35
Mental Health Coordinator I	10.70	$ 534,888.29	$ 10,008.46	$ 544,896.75	$ 140,871.60	$ 685,768.34
Mental Health Worker I	5.00	$ 204,766.16	$ 10,026.79	$ 214,792.95	$ 53,126.70	$ 267,919.64
Mental Health Worker II	5.00	$ 235,665.02	$ 6,806.70	$ 242,471.72	$ 54,339.69	$ 296,811.41
Psychologist IV	1.00	$ 164,576.47	$ 923.60	$ 165,500.08	$ 33,968.18	$ 199,468.25
Registered Nurse II	8.80	$ 871,497.88	$ 33,072.34	$ 904,570.23	$ 227,994.74	$ 1,132,564.96
Registered Nurse IV	1.00	$ 88,967.05	$ 505.30	$ 89,472.34	$ 24,395.76	$ 113,868.11
Registered Nurse V	1.00	$ 129,660.91	$ 650.17	$ 130,311.08	$ 30,782.15	$ 161,093.22
	75.85	**$5,501,438.67**	**$124,206.19**	**$5,625,644.86**	**$1,381,145.15**	**$7,006,790.01**

Form 2A Notes

The BMSC is a multi-service mental health facility located at 165 Quincy Street in Brockton, MA. The center primarily services the communities of Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Holbrook, Pocasset, Rockland, Stoughton, West Bridgewater and Whitman. Norton ESP Services is included under the BMSC umbrella and services the following communities: Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleborough, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, and Taunton. These centers offers a number of behavioral health outpatient and partial hospitalization services in addition to the ESP program's Community-based Location, Crisis Stabilization, and Mobile Crisis Intervention programs.

All costs included in this form include only relevant sub-units related to the ESP program, often referred to as crisis services.[2]

Direct Costs

Personnel

The *Current Operating Budget* period, for the purpose of this report, is assumed as FY15 and as such is derived from the same sources as those outlined in the details related to form 2b, also included in these financial notes. As previously stated, all FY15 personnel data is based on a point in time snapshot of salary levels from the end of CY14. This salary information was annualized through the end of FY15. The *Adjustments* column in Form 2a is an assumed wage index increase based on the average quarterly CMS Market Basket Index Levels between FY15 and FY16 (exhibit 8, CMS Market Basket, page 570). This federally derived adjustment, when applied to the current operating budget produces the form's *Revised Total Cost Period A* (FY16), *Revised Total Cost Period B* (FY17) and *Revised Total Cost Period C* (FY18) columns.

Materials and Supplies

The expenditure object classes included in this analysis are those associated with materials and supplies, including: EE (administrative expense), JJ (programmatic operational services), FF (programmatic facility operational supplies and related expenses), GG (energy costs, utilities and space rental expenses), and N52 (facility infrastructure maintenance and repair tools and supplies). This specifically included objects E01 (office and admin supplies), E12 (subscriptions, memberships and licensing fees), F10 (facility furnishings) and F11 (laundry and cleaning supplies). Object codes related to indirect cost recoupment were excluded as they are contemplated directly through the indirect cost analysis. A full list of expenses can be found in exhibit 2, BMSC FY14 Expenses on page 548.

Other Direct Costs

Travel and Other Employee Reimbursements

Certain non-fringe eligible costs are included under *Travel and Other Employee Reimbursements* including those classified under the following object codes: B02 (In-State Travel), B03 (Overtime Meals), and B91 (Employee Reimbursement Accounts Payable Non-tax). Other employee reimbursements, such as those under object AA (state employee compensation) and D09 (fringe benefit costs recoupment) were excluded as they are contemplated in Form 2b. A full list of expenses

[2] These sub-units as typically reported through the programs Uniform Financial Reports and are classified collectively as Crisis Services, their sub-unit codes are 00AI, 00AT, 00YA, and 00YB

can be found in exhibit 2, BMSC FY14 Expenses on page 548.

Payroll Taxes

Payroll taxes collected by the Commonwealth were not netted from the totals of Form 2A Summary of In-House Cost Estimates. This dollar amount (1.59% for FY15 or $160,099 for FY16 after adjustments) represents taxes paid by DMH to the Commonwealth. As the total FTE and salary levels attributed directly to the SE ESP operations of the vendor are not known, it was not possible to identify a corresponding increase or decrease in payroll taxes paid to the Commonwealth by either vendor as a result of the privatization. Therefore a conservative approach was taken to assume that these dollar amounts would be relatively similar and that the overall impact to the Commonwealth would not be material.

Office Equipment Lease

All expenditures associated with equipment purchase, lease, rental, maintenance, and repair were included in *Office Equipment Lease.* This included all expenses associated with the following internal object classes: KK (programmatic equipment purchase), LL (programmatic equipment tax exempt lease- purchase (ELP), lease and rental, maintenance and repair), N62 (TELP lease/purchase of facility infrastructure maintenance and lawn and grounds), N63 (rental or lease of facility infrastructure maintenance and lawn and grounds equipment), U08 (information technology (IT) equipment TELP lease-purchase), and U09 (IT equipment rental or lease). The *Current Operating Budget* also includes object codes L23 (programmatic facility equipment rental or lease) and L26 (printing/photocopy and micrographics equipment/lease). Object code L23 (programmatic facility equipment rental or lease) however, was not included in its entirety as many expenses associated with this category were accrued and accounted for via indirect expenses associated with agency overhead costs. These costs are internally tracked as costs associated with *fiscal* operations costs. A full list of expenses can be found in exhibit 2, BMSC FY14 Expenses on page 548.

Depreciation, Administration, Plant Maintenance, Plant Ops, and Housekeeping

Costs associated with these areas were allocated based on the proportion of total personnel costs for the entire BMSC facility that were attributable to the ESP program. This was the equivalent to 82.79% of total facility costs. The total amount of depreciation, administration, plant maintenance, plant operations and housekeeping costs for the entire BMSC facility was $6,329,557, of which $5,240,161 was attributed to the ESP program. As previously references, only 10% of these total costs were considered unavoidable as the facility will likely continue to accrue minimal operating expense due to its co-location with other services and current ownership by the Commonwealth of Massachusetts. This calculation is detailed further in exhibit 3, Allocation Calculation on page 562.

Sub-contracted Direct Care

Sub-contracted direct care costs across the entire BMSC facility for FY14 were $1,441,075[3] an amount that is assumed to remain constant through the current operating year. A direct contract cost for the ESP program totaling $881,280 was netted from this amount, as it was directly attributable to the ESP program. A cost of $559,795 remained to be allocated between BMSC's crisis and clinic programs. A total of 9.009%[4] of these costs were attributed to the ESP program, resulting in an additional

[3] FY14 BMSC UFR line 21E
[4] 2014 Time Study conducted by the Department of Mental Health

$50,432 in cost. This calculation can be found in exhibit 6, Worksheet B Crisis on page 568.

Medical Records

Total medical record costs for BMSC were $134,412. Of this amount, $130,478 pertains to categories that are considered fringe eligible.[5] To account for the additional costs related to fringe benefits, $130,478 was multiplied by the fringe rate of 27.27% creating an additional $35,581 of associated costs for a total of $169.994. Using the previously described ESP allocation proportion of 82.79% of total BMSC costs, $140,736 of the total medical records expense was determined to be attributable to the ESP. All Medical Records items can be found in exhibit 2, BMSC FY14 Expenses on page 548.

Leased Equipment

BMSC had a facility-wide leased equipment cost of $24,662.[6] For budgeting purposes, it was assumed that this amount would not vary during the current operating year. Leased office equipment is the primary component of these costs. Using the standard allocation proportion of 82.79%, the total leased equipment costs associated with the ESP program was $20,418. A full list of expenses can be found in exhibit 2, BMSC FY14 Expenses on page 548.

Indirect Costs

All indirect costs including Departmental, Executive Office, and Central Services were calculated using the FY14 Department of Mental Health Cost Allocation Plan dated 11/26/2014.

[5] The current fringe rate of 27.27% was used to identify the additional costs associated
[6] FY14 BMSC UFR line 43E

Form 2B Notes

FY15 salary data is derived from CY 2014 salary data (MRS CY14) amounts. “Annual Wage” includes all costs associated with personnel codes A01 (salaries), A06 (stand-by pay), A08 (overtime pay) and AA1 (supplemental salaries) for all applicable program personnel. “Other Pay” includes costs associated with personnel codes A07 (shift differential pay) for all applicable program personnel. “Basic Pay” is the sum of the annual wage and other pay. “Fringe Benefits” includes costs associated with personnel codes A01, A07 and AA1 from the CY14 payroll data multiplied by the FY15 Fringe Benefit Rate of 27.27%. “Personnel Costs” includes all applicable basic pay and fringe pay. All personnel cost information can be found in exhibit 9, BMSC ESP Payroll Projection on page 571.

Form 2A/2B Data Sources

Exhibit	Title	Used in Form	Description
1	FY15 Revenue by Payer	2/2A	Total revenue collected by payer for the facility in FY15
2	BMSC FY14 Expenses	2A	List of BMSC expenses for Brockton/Norton Crisis sub units, filtered for relevant costs included in form 2A
3	Allocation Calculation	2A	BMSC expenses allocated by Crisis, Clinic, and Overhead (Administration, Housekeeping, Maintenance, and Plant Operations). Allocation methods included for the various overhead expenses included.
4	Administration Worksheet A	2A	Details total Administration costs to be allocated
5	Supplemental Info. Schedule	2A	Unaudited expense amount by category
6	Worksheet B Crisis	2A	Used to determine the Subcontracted Direct Care costs
7	Allocated Cost Calculation	2A	Total overhead costs and amounts to be allocated to crisis.
8	CMS Market Basket	2/2A	Projected CMS Marker Basket Index Levels to project costs to Period C
9	BMSC ESP Payroll Projection	2B	Total FTE counts and estimated salary costs by position for Brockton/Norton
10	BMSC FY 14 UFR	2A/2B	Brockton Multi-Service Center's Uniform Financial Report for Fiscal Year 2014

Exhibit 1: FY15 Revenue by Payer

Revenue by Dept. by Payer
Brockton FY15

NOTE: Medicaid FFP amounts reflect the actual revenue received

Dept	July Billed	Received	August Billed	Received	Sept Billed	Received	Oct Billed	Received	Nov Billed	Received	Dec Billed	Received
BRK Crisis												
B/C	7,967.84	404.05	18,017.00	4,873.29	8,777.22	3,594.00	8,208.21	823.35	14,389.16	1,092.79	38,665.97	1,186.30
Medicaid	249,231.36	316,927.27	286,179.19	177,327.76	268,940.44	179,332.56	273,467.64	134,800.29	274,188.56	192,093.99	334,232.88	259,500.60
Medicaid FFP		158,463.64		88,663.88		89,666.28		67,400.15		96,047.00		129,750.30
Medicare	34,887.00	5,276.83	30,189.00	3,276.64	28,884.00	6,605.58	31,407.00	2,742.38	30,537.00	2,386.30	32,538.00	3,381.24
Comm	129,974.82	32,870.12	117,752.70	39,236.18	114,708.37	38,182.45	119,874.51	52,642.49	99,617.41	38,279.22	117,878.61	35,461.50
Self/Free	17,495.99	-	11,993.16	-	5,677.54	-	18,344.18	-	20,764.77	-	22,224.03	-
Total	439,557.01	355,478.27	464,131.05	224,713.87	426,987.57	227,714.59	451,301.54	191,008.51	439,496.90	233,852.30	545,539.49	299,529.64
% Received		81%		48%		53%		42%		53%		55%

Dept	Jan Billed	Received	Feb Billed	Received	March Billed	Received	April Billed	Received	May Billed	Received	June Billed	Received
BRK Crisis												
B/C	25,690.91	9,692.92	18,716.27	3,152.51	7,553.74	6,107.51	17,574.00	387.14	25,404.00	1,651.15	10,701.00	3,351.47
Medicaid	240,333.30	167,511.80	300,566.08	205,353.89	246,788.66	198,151.15	302,029.26	291,795.59	239,235.15	164,762.27	329,015.57	167,371.48
Medicaid FFP		83,755.90		102,676.95		99,075.58		145,897.80		82,381.14		83,685.74
Medicare	29,058.00	3,266.83	24,099.00	3,829.14	34,566.00	2,364.70	36,750.00	4,083.89	24,447.00	2,057.46	15,993.00	1,504.18
Comm	137,413.47	29,158.24	138,022.50	21,917.40	112,718.65	49,023.67	119,819.91	32,281.25	115,270.73	25,442.54	97,614.64	32,850.02
Self/Free	13,849.28		21,075.00		19,969.88	-	34,591.45	-	26,191.26	-	(26,790.12)	
Total	446,344.96	209,629.79	502,478.85	234,252.94	421,596.93	255,647.03	510,764.62	328,547.87	430,548.14	193,913.42	426,534.09	205,077.15
% Received		47%		47%		61%		64%		45%		48%

	Total YTD Billed	Total YTD Received
BRK Crisis		
B/C	201,665.32	36,316.48
Medicaid	3,344,208.09	2,454,928.65
Medicaid FFP		1,227,464.33
Medicare	353,355.00	40,775.17
Comm	1,420,666.32	427,345.08
Self/Free	185,386.42	-
Total	5,505,281.15	2,959,365.38
% Received		54%

Run Period end: Accounts receivable: INS GRP/INS/ACCT TYPE REPORT

Exhibit 2: Brockton Multi-Service Center Expenses
Fiscal Year 2014

budget fiscal year	fiscal year	fiscal period	department	department name	division	division name	district	sub unit	sub unit name	cash expense amount	appropriation	appropriation name	appropriation type	appropriation type name	fund	object	object name	object class	object class name	activity	activity name	legal name	acceptance date	Program Name	Sch B Line	Fringe Applicable
2014	2015	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	SOUTHEAST AREA	5510	00AI	NORTON CRISIS	215.52	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	F11	Laundry & Cleaning Supplies	FF	FACILITY OPERATIONAL EXPENSES	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	MANSFIELD PAPER CO INC	41828	Crisis	33E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	103.90	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41653	Youth Mob	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	142.60	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41751	Youth Mob	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	672.75	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41515	Youth Mob	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	157.95	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41709	Youth Mob	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	51.36	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B03	Overtime Meals	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41571	Youth Mob	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	122.30	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41751	Youth Mob	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	62.10	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41613	Youth Mob	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	134.70	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41695	Youth Mob	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	63.11	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B03	Overtime Meals	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41571	Youth Mob	23E	No

2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	55.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41571	Youth Mob	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	37.80	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41723	Youth Mob	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	85.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41639	Youth Mob	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	34.65	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41681	Youth Mob	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	21.15	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41529	Youth Mob	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	773.55	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41723	Youth Mob	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	1,684.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41571	Youth Mob	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	104.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41571	Youth Mob	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	37.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41709	Youth Mob	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	25.51	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41653	Youth Mob	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	94.45	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41667	Youth Mob	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	53.10	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41543	Youth Mob	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	157.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41571	Youth Mob	23E	No

2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	1,274.27	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41599	Youth Mob	23E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	108.00	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41599	Youth Mob	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	103.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41613	Youth Mob	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	94.89	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41625	Youth Mob	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	34.20	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41515	Youth Mob	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	1,623.25	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41751	Youth Mob	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	109.80	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41723	Youth Mob	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	697.95	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41543	Youth Mob	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	168.75	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41779	Youth Mob	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	191.60	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41852	Youth Mob	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	1,177.60	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41779	Youth Mob	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	2,211.66	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	E01	Office & Administrative Supplies	EE	ADMINISTRATIVE EXPENSES	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	W. B MASON CO INC	41708	Crisis	33E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	13.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41599	Youth Mob	23E	No

2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	100.70	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41765	Youth Mob	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	1,027.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41695	Youth Mob	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	129.55	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41765	Youth Mob	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	146.70	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41807	Youth Mob	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	42.75	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41543	Youth Mob	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	49.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41543	Youth Mob	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	872.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41821	Youth Mob	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	55.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41695	Youth Mob	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	954.45	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41639	Youth Mob	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	114.90	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41639	Youth Mob	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	157.80	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41807	Youth Mob	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	80.55	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41515	Youth Mob	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	58.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41681	Youth Mob	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	229.50	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41639	Youth Mob	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	7.20	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41501	Youth Mob	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	42.75	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41793	Youth Mob	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	140.85	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41779	Youth Mob	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	81.00	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41779	Youth Mob	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	162.85	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41863	Youth Mob	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	617.40	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41807	Youth Mob	23E	No

2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	200.30	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41852	Youth Mob	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	1,654.60	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41667	Youth Mob	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	132.90	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41501	Youth Mob	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	52.65	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41863	Youth Mob	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	230.30	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41852	Youth Mob	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	1,666.93	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41852	Youth Mob	23E	No
2014	2014	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	4.95	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41487	Youth Mob	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	37.80	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3014	RECOVERY LEARNING COMMUNITY		41723	Crisis	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	156.15	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41723	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	86.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41571	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	291.55	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41737	Youth Mob	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	93.15	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41653	Crisis	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	14.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41667	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.80	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3015	CLIENT & COMMUNITY EMPOWERMENT		41821	Crisis	23E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	63.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41599	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YA	YOUTH MOBILE CRISIS INTERVENTION NORTON	48.15	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41501	Youth Mob	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	136.35	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41501	Crisis	23E	No

2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	134.55	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41793	Crisis	23E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	14.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41599	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	270.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41821	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	7.20	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3014	RECOVERY LEARNING COMMUNITY		41751	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	104.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41751	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	129.60	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41779	Crisis	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	93.15	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41653	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	133.20	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41751	Crisis	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	82.80	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41723	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	103.50	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41695	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	86.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41571	Crisis	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41667	Crisis	13E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	171.45	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41821	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41757	Crisis	13E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	144.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41709	Crisis	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41729	Crisis	13E	No

2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	176.18	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41543	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41513	Crisis	13E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	103.95	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41557	Crisis	23E	No
2014	2014	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41484	Crisis	13E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	135.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41625	Crisis	23E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	79.65	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41599	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41575	Crisis	13E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	197.33	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41599	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	117.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41613	Crisis	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	103.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3015	CLIENT & COMMUNITY EMPOWERMENT		41852	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	61.20	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41751	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41638	Crisis	13E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	103.50	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41695	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	60.30	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3015	CLIENT & COMMUNITY EMPOWERMENT		41779	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	289.12	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41543	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	75.60	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41807	Crisis	23E	No

2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	207.45	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41695	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	136.35	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41501	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	142.35	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41821	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	54.45	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41695	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	75.60	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41625	Crisis	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	255.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41852	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	21.60	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41807	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41695	Crisis	13E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41604	Crisis	13E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	104.80	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41653	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	67.50	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41515	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	83.70	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3049	ADULT RESIDENTIAL SERVICES		41515	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	888.30	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41515	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	45.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41639	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41547	Crisis	13E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	44.55	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41821	Crisis	23E	No

2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	163.35	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41751	Crisis	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	19.35	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41723	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	102.60	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3049	ADULT RESIDENTIAL SERVICES		41613	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	67.50	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41571	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	15.30	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41515	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	904.95	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41639	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	90.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41695	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	99.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3049	ADULT RESIDENTIAL SERVICES		41639	Crisis	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	1,816.10	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41667	Crisis	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	103.50	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41852	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	134.55	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41793	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	18.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3103	NURSING SERVICE		41807	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	1,126.80	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41695	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41786	Crisis	13E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	969.75	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41599	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	176.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41821	Crisis	23E	No

2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	28.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L23	Programmatic Facility Equipment Rental or Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3135	LAUNDRY, LINEN & CLOTHING SERVICES	AUTOMATIC LAUNDRY SERVICE INC	41820	Crisis	13E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	201.05	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3049	ADULT RESIDENTIAL SERVICES		41667	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	141.25	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41571	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	150.25	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41751	Crisis	23E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41604	Crisis	43E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	201.60	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41639	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	59.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41779	Crisis	23E	No
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	374.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41585	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	51.30	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41737	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	959.85	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41779	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	72.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41807	Crisis	23E	No
2014	2014	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	24.75	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41487	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	140.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41793	Crisis	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	42.30	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41723	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	114.30	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41779	Crisis	23E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	103.45	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41667	Crisis	23E	No

2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	303.20	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41653	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	347.85	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41681	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	1,820.95	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41751	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	575.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	F10	Facility Furnishings	FF	FACILITY OPERATIONAL EXPENSES	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	RICHMOND HARDWARE	41696	Crisis	33E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	45.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41667	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	72.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41639	Crisis	23E	No
2014	2014	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41484	Crisis	43E	No
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41667	Crisis	43E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	193.05	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41515	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	108.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41501	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	50.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3140	PASTORAL SERVICES		41501	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	37.35	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41751	Crisis	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	954.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41723	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	98.10	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41737	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41575	Crisis	43E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	169.10	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3049	ADULT RESIDENTIAL SERVICES		41571	Crisis	23E	No

2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	194.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41737	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	152.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41765	Crisis	23E	No
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41513	Crisis	43E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	61.20	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41723	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41547	Crisis	43E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	818.10	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41543	Crisis	23E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	49.50	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41723	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	14.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41543	Crisis	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	83.25	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41852	Crisis	23E	No
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41695	Crisis	43E	No
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41729	Crisis	43E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	119.70	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41793	Crisis	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	204.80	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41852	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	1,485.15	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41571	Crisis	23E	No
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	198.80	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41571	Crisis	23E	No

2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	310.95	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41543	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	144.00	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		41543	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	943.65	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41807	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	243.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41807	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	8.55	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		41543	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	63.90	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3049	ADULT RESIDENTIAL SERVICES		41543	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	60.75	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41793	Crisis	23E	No
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41638	Crisis	43E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	247.05	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41793	Crisis	23E	No
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41820	Crisis	43E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	74.25	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41765	Crisis	23E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AI	NORTON CRISIS	2,002.20	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41852	Crisis	23E	No
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41757	Crisis	43E	No
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	336.05	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41852	Crisis	23E	No
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00YB	YOUTH MOBILE CRISIS INTERVENTION BROCKTON	1,366.00	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	E12	Subscriptions, Memberships & Licensing Fees	EE	ADMINISTRATIVE EXPENSES	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	EMERY PRATT	41535	Youth Mob	33E	No

2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00A1	NORTON CRISIS	117.40	50460000	MENTAL HEALTH SERVICES FOR ADULT CLIENTS	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		41765	Crisis	23E	No
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5510	00AT	BROCKTON CRISIS	282.37	55402689	BROCKTON MULTI SERVICE CENTER C.118,	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN /REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	41786	Crisis	43E	No

Exhibit 3: Allocation Calculation

Allocation Calculations
Brockton Multi Service Center
Fiscal Year 2014

Sum of cash expense amount	Column Labels											
Row Labels	Admin (all)	Clinic	Crisis	CRS	Housekeeping (all)	Maintenance (all)	Non-Reimbursable	PACT	Pharmacy (all)	Plant Operations (all)	Youth Mobile Crisis	Grand Total
13E			1,848							282		2,130
15E	55,499			4,909		109,588			2,993	185,580		358,570
21E		1,122,158										1,122,158
23E	4,206	8,997	26,305								20,646	60,154
24S		172,073	1,838,244								861,936	2,872,253
26E						13,996				156		14,152
28E	851				6,358				67,595	1,807		76,612
2S		81,158	267,372								263,616	612,146
33E	27,937	308	3,002	29	10,182	3,998			2,586		1,366	49,407
35S		85,367	54,965									140,332
43E	18,630		3,388			8,932			3,847			34,798
4E	511,743											511,743
55E							56,340					56,340
5E					80,784	118,749				224,916		424,448
5S		140,887										140,887
8S		102,396	1,954,027									2,056,424
9E	10,461	15,469	58,427		1,147	1,686					15,983	103,174
23S		507,515										507,515
PACT								51,897				51,897
35E	292											292
Grand Total	**629,618**	**2,236,329**	**4,207,580**	**4,937**	**98,471**	**256,949**	**56,340**	**51,897**	**77,021**	**412,741**	**1,163,546**	**9,195,429**

Expenses to allocate= 1,474,800 Expenses for inclusion and allocation = 9,082,255 Non reimburseable not included in UFR = 113,174

Brockton Department Salaries as a percentage to the total

Maint	Plant Ops	HK	Clinic	Crisis	Total	Total Salaries	Variance
$ 118,749	$ 224,916	$ 80,784	$ 1,089,396	$ 5,240,161	$ 6,754,004	$ 7,313,105	**$ (559,101)**
1.76%	3.33%	1.20%	16.13%	77.59%	100.00%		

Clinic	$1,089,396	17.21%
Crisis	$5,240,161	82.79%
Total	$6,329,557	100.00%

$ 511,743	Admin Salaries
$ 47,358	PACT Salaries
$ 559,101	

Allocation of Administration, HOCAP and Depreciation costs to Maintenance, Plant Ops and Housekeeping

		Maint	Plant Ops	HK	Clinic*	Crisis*	Total
Cost Center	Admin to be allocated	1.76%	3.33%	1.20%	16.13%	77.59%	100.00%
4E	$ 511,743	$ 8,997	$ 17,042	$ 6,121	$ 82,542	$ 397,040	$ 511,743
5E	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9E	$ 10,461	$ 184	$ 348	$ 125	$ 1,687	$ 8,116	$ 10,461
13E	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14E	$ 64,877	$ 1,141	$ 2,160	$ 776	$ 10,464	$ 50,335	$ 64,877
15E	$ 55,499	$ 976	$ 1,848	$ 664	$ 8,952	$ 43,059	$ 55,499
23E	$ 4,206	$ 74	$ 140	$ 50	$ 678	$ 3,263	$ 4,206
28E	$ 851	$ 15	$ 28	$ 10	$ 137	$ 661	$ 851
33E	$ 27,937	$ 491	$ 930	$ 334	$ 4,506	$ 21,675	$ 27,937
35E	$ 292	$ 5	$ 10	$ 3	$ 47	$ 226	$ 292
42E	$ -	$ -	$ -	$ -	$ -	$ -	$ -
43E	$ 18,630	$ 328	$ 620	$ 223	$ 3,005	$ 14,454	$ 18,630
37E	$ 995,292	$ 17,499	$ 33,144	$ 11,905	$ 160,537	$ 772,207	$ 995,292
Grand Total	**$ 1,689,786**	**$ 29,710**	**$ 56,272**	**$ 20,211**	**$ 272,556**	**$ 1,311,037**	**$ 1,689,786**

Total Costs Including Admin Allocation			
	$ 286,659	$ 469,013	$ 118,682
			$ 874,354

* Remaining Administrative costs are allocated to Clinic and Crisis programs via the methodology on the UFR.

Costs Allocated to non-clinic, non-crisis departments

	Sq. Ft	%
Clinic/Crisis	16,791	71.31%
Non-Clinic/Crisis	6,757	28.69%
Total	23,548	100%

Cost Center	Maint/Ops/HK From Above	Clinic/Crisis	Non-Clinic/Crisis	Check
4E	32,160	22,932	9,228	32,160
5E	424,448	302,654	121,794	424,448
9E	3,491	2,489	1,002	3,491
13E	282	201	81	282
14E	4,077	2,907	1,170	4,077
15E	298,657	212,958	85,698	298,657
23E	264	188	76	264
26E	14,152	10,091	4,061	14,152
28E	8,219	5,861	2,358	8,219
33E	15,935	11,363	4,573	15,935
35E	18	13	5	18
37E	62,548	44,600	17,948	62,548
42E	-	-	-	-
43E	10,103	7,204	2,899	10,103
Total	**874,354**	**623,462**	**250,892**	**874,354**

Fringe Costs for Admin allocated to Maintenance, Plant Operations, and Housekeeping
Admin Salary Costs allocated to other Overhead departments (Based on Salary Percentages calculated on previous page)

Sum of SumOfcash_expense_amount	object			
Sch B Line	A01	A07	AA1	Total
4E	$ 507,179	$ -	$ -	$ 507,179

Fringe Cost @ 26.26%: $133,185.00

Admin Fringe Allocated to Maintenance, Plant Operations and Housekeeping

Maint	Plant Ops	HK	Clinic	Crisis	Total
1.76%	3.33%	1.20%	16.13%	77.59%	100.00%
2,342	4,435	1,593	21,482	103,333	133,185

Sum of SumOfcash_expense_amount		object			
Program Name	Sch B Line	A01	A07	AA1	Grand Total
Housekeeping (all)	5E	$ 79,240	$ 10	$ -	$ 79,250
Maintenance (all)	5E	$ 110,722	$ -	$ -	$ 110,722
Plant Operations (all)	5E	$ 185,320	$ 8,022	$ -	$ 193,343
Grand Total		$ 375,283	$ 8,032	$ -	$ 383,315

Fringe Cost @ 26.26%: $100,658.41 Total for Allocation
$109,028.27 Total Including Admin Fringe Above

Costs Allocated to non-clinic, non-crisis departments

	Sq. Ft	%
Clinic/Crisis	16,791	71.31%
Non-Clinic/Crisis	6,757	28.69%
Total	23,548	100%

		Clinic/Crisis	Non Clinic/Crisis	Total
Fringe	10E	77,743	31,285	109,028

Worksheet A Entry Amounts

Expense Totals								Youth Mobile Crisis	**Total**	Clinic (B)	Crisis (B)	A12 & A13 Clinic Part C	Non Clinic/Crisis	**Final Total**
Sch B Line	Admin(all.)	Maint (all.)	Plant Ops (all.)	HK (all.)	Pharmacy (all.)	Clinic	Crisis	$ 263,615.7	**$ 263,615.70**	$ (81,158.23)	$ (514,951.71)	$ (16,036)		**$ (332,494)**
2S	$ -	$ -	$ -	$ -	$ -	$ 81,158.23	$ 267,372.39	$ -	**$ 348,530.62**	$ (138,658.99)	$ -	$ (2,228)		**$ 207,644**
5S	$ -	$ -	$ -	$ -	$ -	$ 140,886.64	$ -	$ -	**$ 140,886.64**	$ -	$ -	$ -		**$ 140,887**
7S	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**	$ (102,396.25)	$ (1,917,452.21)	$ (36,575)		**$ (2,056,424)**
8S	$ -	$ -	$ -	$ -	$ -	$ 102,396.25	$ 1,954,027.36	$ -	**$ 2,056,423.61**	$ -	$ 8,807.51	$ (8,808)		**$ 2,056,424**
9S	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -		**$ -**
22S	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**	$ (499,944.27)	$ 19,939.97	$ (27,511)		**$ (507,515)**
23S	$ -	$ -	$ -	$ -	$ -	$ 507,515.13	$ -	$ 861,935.8	**$ 1,369,450.93**	$ (143,994.38)	$ (2,700,179.82)	$ (28,079)		**$ (1,502,802)**
24S	$ -	$ -	$ -	$ -	$ -	$ 172,073.30	$ 1,838,244.02	$ -	**$ 2,010,317.32**	$ -	$ 826.49	$ (826)		**$ 2,010,317**
25S	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -		**$ -**
33S	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -		**$ -**
34S	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**	$ (85,366.52)	$ (54,965.29)	$ -		**$ (140,332)**
35S	$ -	$ -	$ -	$ -	$ -	$ 85,366.52	$ 54,965.29	$ -	**$ 140,331.81**	$ -	$ -		$ (9,228)	**$ 131,104**
4E	$ 511,743	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 511,742.51**	$ -	$ -		$ (121,794)	**$ 389,949**
5E	$ -	$ 118,749	$ 224,916	$ 80,784	$ -	$ -	$ -	$ 15,982.88	**$ 440,430.66**	$ (15,469.38)	$ (74,410.36)		$ (1,002)	**$ 349,549**
9E	$ 10,461	$ 1,686	$ -	$ 1,147	$ -	$ 15,469.38	$ 58,427.48	$ -	**$ 87,190.74**	$ (286,103.83)	$ (1,218,769.76)		$ (31,285)	**$ (1,448,968)**
10E	$ 1,756,140	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,756,140.47**	$ -	$ (1,848.00)		$ (81)	**$ 1,754,212**
13E	$ -	$ -	$ 282	$ -	$ -	$ -	$ 1,848.00	$ -	**$ 2,130.00**	$ -	$ -		$ (1,170)	**$ 960**
14E	$ 64,877	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 64,876.86**	$ -	$ (2,993.33)		$ (85,698)	**$ (23,815)**
15E	$ 55,499	$ 109,588	$ 185,580	$ -	$ 2,993	$ -	$ -	$ -	**$ 353,660.75**	$ (509,363.27)	$ (931,712.01)		$ -	**$ (1,087,415)**
21E	$ -	$ -	$ -	$ -	$ -	$ 1,441,075.28	$ -	$ 20,645.52	**$ 1,461,720.80**	$ (8,997.17)	$ (46,950.60)		$ (76)	**$ 1,405,697**
23E	$ 4,206	$ -	$ -	$ -	$ -	$ 8,997.17	$ 26,305.08	$ -	**$ 39,508.40**	$ -	$ -		$ (4,061)	**$ 35,448**
26E	$ -	$ 13,996	$ 156	$ -	$ -	$ -	$ -	$ -	**$ 14,151.87**	$ (66,362.45)	$ (100,950.71)		$ (2,358)	**$ (155,520)**
28E	$ 851	$ -	$ 1,807	$ 6,358	$ 160,655	$ -	$ -	$ 1,366.00	**$ 171,037.61**	$ (16,224.89)	$ (28,581.01)		$ (4,573)	**$ 121,659**
33E	$ 27,937	$ 3,998	$ -	$ 10,182	$ 2,586	$ 307.98	$ 3,002.18	$ -	**$ 48,012.52**	$ -	$ -		$ (5)	**$ 48,007**
35E	$ 292	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 291.65**	$ -	$ -		$ (17,948)	**$ (17,656)**
37E	$ 995,292	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 995,292.00**	$ -	$ -		$ -	**$ 995,292**
42E	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ (7,235.84)		$ (2,899)	**$ (10,135)**
43E	$ 18,630	$ 8,932	$ -	$ -	$ 3,847	$ -	$ 3,388.44	$ -	**$ 34,797.72**	$ -	$ -		$ -	**$ 34,798**
55E	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,163,545.90	**$ 12,310,541.19**	$ (1,954,039.63)	$ (7,571,426.67)	$ (120,063)	$ (282,177)	**$ 2,398,871**
Grand Total	$ 3,445,927	$ 256,949	$ 412,741	$ 98,471	$ 170,081	$ 2,555,245.88	$ 4,207,580.24						Total From UFR Admin Wksht A	$ 2,390,775
													Variance	$ 8,096

Exhibit 4: Administration Worksheet A

Cost Center	Administration	Housekeeping	Maintenance	Plant Operations	Non-reimbursable	Starting Total Wrksht A
4E	511,743	-	-	-	-	511,743
5E	-	80,784	118,749	224,916	-	424,448
9E	10,461	1,147	1,686	-	-	13,294
10E	1,756,140	-	-	-	-	1,756,140
13E	-	-	-	282	-	282
14E	64,877	-	-	-	-	64,877
15E	55,499	-	109,588	185,580	-	350,667
21E	-	-	-	-	-	-
22E	-	-	-	-	-	-
23E	4,206	-	-	-	-	4,206
24E	-	-	-	-	-	-
26E	-	-	13,996	156	-	14,152
28E	851	6,358	-	1,807	-	9,017
33E	27,937	10,182	3,998	-	-	42,117
35E	292	-	-	-	-	292
37E	995,292	-	-	-	-	995,292
42E	-	-	-	-	-	-
43E	18,630	-	8,932	-	-	27,562
55E	-	-	-	-	-	-
	3,445,927	98,471	256,949	412,741	-	4,214,088

Cost Center	Starting Total Wrksht A	Amount Removed for Non clinic Activity	Service Costs (Recorded Directly on Sch B	Other Cost Removal	Worksheet A Entry Amounts
4E	511,743	(9,228)			502,514.37
5E	424,448	(121,794)			302,654.27
9E	13,294	(1,002)			12,292.23
10E	1,756,140	(31,285)	$ (1,509,860.59)		202,558.35
13E	282	(81)			201.08
14E	64,877	(1,170)			63,706.95
15E	350,667	(85,698)			264,969.16
21E	-	-			-
22E	-	-			-
23E	4,206	(76)			4,130.30
24E	-	-			-
26E	14,152	(4,061)			10,091.05
28E	9,017	(2,358)	(6,659)		-
33E	42,117	(4,573)	(37,544)		-
35E	292	(5)			286.39
37E	995,292	(17,948)			977,344.11
42E	-	-			-
43E	27,562	(2,899)			24,662.93
55E	-	-			-
	4,214,088	(282,177)	(1,554,063)	-	2,365,411.20

Exhibit 5: Supplemental Information Schedule

ORGANIZATION: Brockton Multi-Service Center **FY END:** 6/30/2014 **FEIN**: 346002282

REVENUE	**Total Organization**	**Admin.(M&G)**	**Fund Raising**	**Total All Prog**
1R Contributions, Gifts, Legacies, Bequests				
2R Gov. In-Kind/Capital Budget		XXXXXXXXXX	XXXXXXXXXX	
3R Private IN-Kind				
4R **Total Contributions and In-Kind**				
5R Mass Gov. Grant		XXXXXXXXXX	XXXXXXXXXX	
6R Other Grant (exclud. Fed.Direct)				
7R **Total Grants**				
8R Dept. of Mental Health (DMH)		XXXXXXXXXX	XXXXXXXXXX	
9R Dept.of Developmental Services(DDS/DMR)		XXXXXXXXXX	XXXXXXXXXX	
10R Dept. of Public Health (DPH)		XXXXXXXXXX	XXXXXXXXXX	
11R Dept.of Children and Families (DCF/DSS)		XXXXXXXXXX	XXXXXXXXXX	
12R Dept. of Transitional Assist (DTA/WEL)		XXXXXXXXXX	XXXXXXXXXX	
13R Dept. of Youth Services (DYS)		XXXXXXXXXX	XXXXXXXXXX	
14R Health Care Fin & Policy (HCF)-Contract		XXXXXXXXXX	XXXXXXXXXX	
15R Health Care Fin & Policy (HCF)-UCP		XXXXXXXXXX	XXXXXXXXXX	
16R MA. Comm. For the Blind (MCB)		XXXXXXXXXX	XXXXXXXXXX	
17R MA. Comm. for Deaf & H H (MCD)		XXXXXXXXXX	XXXXXXXXXX	
18R MA. Rehabilitation Commission (MRC)		XXXXXXXXXX	XXXXXXXXXX	
19R MA. Off. for Refugees & Immigr.(ORI)		XXXXXXXXXX	XXXXXXXXXX	
20R Dept.of Early Educ. & Care (EEC)-Contract		XXXXXXXXXX	XXXXXXXXXX	
21R Dept.of Early Educ. & Care (EEC)-Voucher		XXXXXXXXXX	XXXXXXXXXX	
22R Dept of Correction (DOC)		XXXXXXXXXX	XXXXXXXXXX	
23R Dept. of Elementary & Secondary Educ. (DOE)		XXXXXXXXXX	XXXXXXXXXX	
24R Parole Board (PAR)		XXXXXXXXXX	XXXXXXXXXX	
25R Veteran's Services (VET)		XXXXXXXXXX	XXXXXXXXXX	
26R Ex. Off. of Elder Affairs (ELD)		XXXXXXXXXX	XXXXXXXXXX	
27R Div.of Housing & Community Develop(OCD)		XXXXXXXXXX	XXXXXXXXXX	
28R POS Subcontract		XXXXXXXXXX	XXXXXXXXXX	
29R Other Mass. State Agency POS		XXXXXXXXXX	XXXXXXXXXX	
30R Mass State Agency Non - POS		XXXXXXXXXX	XXXXXXXXXX	
31R Mass. Local Govt/Quasi-Govt. Entities		XXXXXXXXXX	XXXXXXXXXX	
32R Non-Mass. State/Local Government		XXXXXXXXXX	XXXXXXXXXX	
33R Direct Federal Grants/Contracts		XXXXXXXXXX	XXXXXXXXXX	
34R Medicaid - Direct Payments	2,351,646	XXXXXXXXXX	XXXXXXXXXX	2,351,646
35R Medicaid - MBHP Subcontract		XXXXXXXXXX	XXXXXXXXXX	
36R Medicare	3,353	XXXXXXXXXX	XXXXXXXXXX	3,353
37R Mass. Govt. Client Stipends		XXXXXXXXXX	XXXXXXXXXX	
38R Client Resources		XXXXXXXXXX	XXXXXXXXXX	
39R Mass. Publicly sponsored client offsets		XXXXXXXXXX	XXXXXXXXXX	
40R Other Publicly sponsored client offsets		XXXXXXXXXX	XXXXXXXXXX	
41R Private Client Fees (excluding 3rd Pty)	368,210	XXXXXXXXXX	XXXXXXXXXX	368,210
42R Private Client 3rd Pty/other offsets	350,267	XXXXXXXXXX	XXXXXXXXXX	350,267
43R **Total Assistance and Fees**	3,073,476	XXXXXXXXXX	XXXXXXXXXX	3,073,476
44R Federated Fundraising				
45R Commercial Activities				
46R Non-Charitable Revenue				
47R Investment Revenue				
48R Other Revenue				
49R Allocated Admin (M&G) Revenue	XXXXXXXXXX			
50R Released Net Assets-Program				
51R Released Net Assets-Equipment				
52R Released Net Assets-Time				
53R **TOTAL REVENUE**	3,073,476	XXXXXXXXXX	XXXXXXXXXX	3,073,476
54R **TOTAL EXPENSE = 56E**	11,878,748			11,878,748
55R **OPERATING RESULTS**	(8,805,272)	XXXXXXXXXX	XXXXXXXXXX	(8,805,272)

COMPENSATION DISCLOSURE *Enter all compensation (salary, benefit packages, vehicles, consultant payments, loans, etc.) from the entity & its related parties/affiliates to organization principals. Attach schedule of non-salary items.*

		Reporting Entity Compensation		**Compensation from Other Entities**	
	Name & Title	Salary	Other	Salary	Other
1C					
2C					
3C					
4C					
5C					

MA. Surplus Revenue Retention	**Starting Balance**	**Expended Amount**	**Accrual Amount**	**Liability Amt.**
Prior Year Ma. Revenue				

Comm. of MA cost reimbursement overbilling (preliminary calc. subject to adjustment) 0 0

ORGANIZATION: Brockton Multi-Service Center **FY END:** 6/30/2014 **FEIN:** 946002282

ORGANIZATION SUPPLEMENTAL INFORMATION SCHEDULE A - Unaudited

	Total Organization		Admin (M&G)		Fund Raising		Total All Programs	
EXPENSE	**FTE**	**Expense**	**FTE**	**Expense**	**FTE**	**Expense**	**FTE**	**Expense**
1E **Total Direct Prog.Staff FTE/Exp 101-138**	85.26	6,209,494	XXXX	XXXXXXXXXX	XXXX	XXXXXXXXXX	85.26	6,209,494
2E Chief Executive Officer - FTE/Exp.								
3E Chief Financial Officer - FTE/Exp.								
4E Accting/Clerical/Support FTE/Expense	8.81	502,514	8.81	502,514				
5E Admin Maint/House-Grndskeeping FTE/Exp	9.79	302,654	9.79	302,654				
6E **Total Admin Employee FTE/Expense 410**	18.60	805,169	18.60	805,169				
7E Commercial Products & Svs/Mkting FTE/Exp					XXXX	XXXXXXXXXX		
8E **Total FTE/Salary/Wages**	103.86	7,014,662	18.60	805,169			85.26	6,209,494
9E Payroll Taxes 150		102,172		12,292				89,880
10E Fringe Benefits 151		1,695,303		202,558				1,492,745
11E Accrual Adjustments								
12E **Total Employee Compensation & Rel. Exp.**		8,812,137		1,020,019				7,792,118
13E Facility and Prog. Equip.Expenses 301, 390		2,049		201				1,848
14E Facility & Prog. Equip. Depreciation 301		63,707		63,707				
15E Facility Operation/Maint./Furn.390		267,962		264,969				2,993
16E Facility General Liability Insurance 390								
17E **Total Occupancy**		333,719		328,877				4,841
18E Direct Care Consultant 201								
19E Temporary Help 202								
20E Clients and Caregivers Reimb./Stipends 203				XXXXXXXXXX		XXXXXXXXXX		
21E Subcontracted Direct Care 206		1,441,075		XXXXXXXXXX		XXXXXXXXXX		1,441,075
22E Staff Training 204								
23E Staff Mileage / Travel 205		60,078		4,130				55,948
24E Meals 207								
25E Client Transportation 208				XXXXXXXXXX		XXXXXXXXXX		
26E Vehicle Expenses 208		10,091		10,091				
27E Vehicle Depreciation 208								
28E Incidental Medical /Medicine/Pharmacy 209		167,313		XXXXXXXXXX		XXXXXXXXXX		167,313
29E Client Personal Allowances 211				XXXXXXXXXX		XXXXXXXXXX		
30E Provision Material Goods/Svs./Benefits 212				XXXXXXXXXX		XXXXXXXXXX		
31E Direct Client Wages 214				XXXXXXXXXX		XXXXXXXXXX		
32E Other Commercial Prod. & Svs. 214								
33E Program Supplies & Materials 215		44,806		XXXXXXXXXX		XXXXXXXXXX		44,806
34E Non Charitable Expenses								
35E Other Expense		286		286				
36E **Total Other Program Expense**		1,723,650		14,508				1,709,142
37E Management Fees 410		977,344		977,344				XXXXXXXXXX
38E Fundraising Fees 410				XXXXXXXXXX				XXXXXXXXXX
39E Legal Fees 410								XXXXXXXXXX
40E Audit Fees 410								XXXXXXXXXX
41E Management Consultant 410								XXXXXXXXXX
42E Other Professional Fees & Other Admin. Expenses 410								
43E Leased Office/Program Office Equip.410,390		31,899		24,663				7,236
44E Office Equipment Depreciation 410								
45E Admin. Vehicle Expenses 410								XXXXXXXXXX
46E Admin. Vehicle Depreciation 410								XXXXXXXXXX
47E Directors & Officers Insurance 410								XXXXXXXXXX
48E Program Support 216				XXXXXXXXXX				
49E Professional Insurance 410								
50E Working Capital Interest 410								
51E **Total Direct Administrative Expense**		1,009,243		1,002,007				7,236
52E Admin (M&G) Reporting Center Allocation		XXXXXXXXXX		(2,365,411)		0		2,365,411
53E **Total Reimbursable & Fundraising Expense**		11,878,748		0		0		11,878,748
54E Direct State/Federal Non-Reimbursable Expense						XXXXXXXXXX		
55E Allocation of State/Fed Non-Reimbursable Expense		XXXXXXXXXX						
56E **TOTAL EXPENSE = 56R**		11,878,748						11,878,748
NON-REIMBURSABLE EXPENSE DETAIL	*Note to Readers*: Please see Schedule B Note to Readers regarding appropriate Non-Reimbursable Exp.							
1N Direct Employee Compensation & Related Exp.						XXXXXXXXXX		
2N Direct Occupancy						XXXXXXXXXX		
3N Direct Other Program/Operating						XXXXXXXXXX		
4N Direct Subcontract Expense						XXXXXXXXXX		
5N Direct Administrative Expense						XXXXXXXXXX		
6N Direct Other Expense						XXXXXXXXXX		
7N Direct Depreciation						XXXXXXXXXX		
8N Total Direct Non-Reimbursable (must tie to 54E)				0		XXXXXXXXXX		
9N Total Direct and Allocated Non-Reimbursable (54E+55E)						XXXXXXXXXX		
10N Eligible Non-Reimb./Fundraising Exp. Revenue Offsets		0		XXXXXXXXXX		XXXXXXXXXX		0
11N Capital Budget Revenue Adjustments		0				XXXXXXXXXX		0
12N Excess of Non-Reimb./Fundraising Expense over Offsets		0		XXXXXXXXXX		XXXXXXXXXX		0
Description of Admin (M&G) Direct Non-Reimbursable Exp.								

Exhibit 6: Worksheet B Crisis

Crisis Costs
Brockton Multi Service Center
Fiscal Year 2014

Schedule B Line	Total	Adjustments	Remove A12	Remove Part	Adjusted Balan	FTE
2S	530,988	(219,640)	-	(16,036)	295,311.50	2.53
8S	1,954,027	(801,017)	(36,575)	-	1,116,434.78	11.19
9S	-	290,624	(8,808)	-	281,816.34	4.58
23S	-	1,102,632	(6,447)	(13,493)	1,082,692.31	13.55
24S	2,700,180	(2,323,002)	-		377,177.39	4.63
25S	-	1,040,116	(826)	-	1,039,289.49	14.28
33S	-	70,224	-	-	70,223.80	1.00
34S	-	840,064	-	-	840,064.16	18.02
35S	54,965		-	-	54,965.29	1.00
9E	74,410				74,410.36	
10E	-	1,223,757		(7,754)	1,216,002.34	
13E	1,848				1,848.00	
15E	-	2,993			2,993.33	
23E	46,951				46,950.60	
28E	-	100,951			100,950.71	
33E	4,368	24,213			28,581.01	
42E	-				-	
43E	3,388	3,847			7,235.84	
Grand Total	5,371,126	1,355,761	(52,656)	(37,284)	6,636,947	70.78

Fringe Eligible Salary (A01, A07)		$ 4,641,164
Fringe Benefits @ 26.26%		$ 1,218,770 (10E)

28E and 33E Allocation	Days of Service	DOS %	28E	33E
Crisis	13,058	60%	100,951	24,213
Clinic	8,584	40%	66,362	15,917
Total	21,642		167,313	40,130

	Direct Contract Cost	Med Service Allocation based on Time Studies	Total
21E	881,280	50,432	931,712.01

sub unit	(Multiple Items)

Sum of Sum Of dollar amount	Column Labels								
Row Labels	**A01**	**A06**	**A07**	**A08**	**A12**	**A13**	**A14**	**AA1**	**Grand Total**
23S	937102.69	5280	13859.46	139403.17	290.94	6156.02		540	1102632.28
24S	290913.41		6090.31	27840.86				2511.74	327356.32
25S	914466.74		22087.38	82528.07		826.49		20207.3	1040115.98
2S	234723.02	2805	893.72	78926.75					317348.49
33S	63849.28		210	5384.52				780	70223.8
34S	732549.13		23219.13	77736.41			5000	1559.49	840064.16
35S	54752.89								54752.89
8S	1014288.14		35531.49	86056.01	14163.04	22412.11		4221.08	1176671.87
9S	236136.3		10207.02	15008.39	2407.77	6399.74		20464.63	290623.85
Grand Total	**4478781.6**	**8085**	**112098.51**	**512884.18**	**16861.75**	**35794.36**	**5000**	**50284.24**	**5219789.64**

Sum of cash expense amount	object								
Program Name	**A01**	**A07**	**AA1**	**A06**	**A08**	**A12**	**A13**	**A14**	**Grand Total**
Crisis	3534130.34	97542.07	38519	5239.25	387348.78	16861.75	34967.87		4114609.06
Youth Mobile Crisis	962906.89	15051.09	12005.81	2877.25	126883.97		826.49	5000	1125551.5
Grand Total	**4497037.23**	**112593.16**	**50524.81**	**8116.5**	**514232.75**	**16861.75**	**35794.36**	**5000**	**5240160.56**

Fringe Eligible Salary (A01, A07)	4,660,155
Fringe Benefits @ 26.26%	1,223,757

Exhibit 7: Allocation Cost Calculation

Brockton Multi Service Center

Fiscal Year 2014

	Depreciation	Admin	Departmental	Executive	Central Services	Maint.	Plant Ops.	HK	Medical Records	Leased Equip
Total Cost	63,707	436,064	683,205	212,036	82,103	225,150	370,659	99,472	168,352	24,663
Total	52,544	359,652	563,486	174,881	67,716	185,697	305,708	82,042	138,852	20,341

Administration Cost Allocation Breakdown

	Expense alloc.	% To Total
Total Admin	2,365,411	
Departmental Allocation	683,205	28.88%
Executive Allocation	212,036	8.96%
Central Service Cost	82,103	3.47%
Facility Admin	1,388,067	58.68%

Admin Cost Allocated to Crisis	1,950,918	82.48%

Sources: OSD UFR FY14 Cost Report, FY14 DMH Home Office Cost Allocation Plan

Percent of Total Admin to Clinic/Crisis	71.31%

Program Name	Sch B Line	A01	A07	AA1	Grand Total	Fringe
Housekeeping (all)	5E	79,240	10	-	79,250	20,811
Maintenance (all)	5E	110,722	-	-	110,722	29,076
Plant Operations (all)	5E	185,320	8,022	-	193,343	50,772
Grand Total		**375,283**	**8,032**	-	**383,315**	100,658

Exhibit 8: CMS Market Basket

Summary Table - CMS Market Basket Index Levels and Four-Quarter Moving Average Percent Changes

Market Basket	2013 Q4	2014 Q1	2014 Q2*	2014 Q3*	2014 Q4*	2015 Q1*	2015 Q2*	2015 Q3*	2015 Q4*	2016 Q1*	2016 Q2*	2016 Q3*	2016 Q4*	2017 Q1*	2017 Q2*	2017 Q3*	2017 Q4*	2018 Q1*	2018 Q2*	2018 Q3*
2010-based Inpatient Hospital:																				
Index Levels	1.079	1.087	1.096	1.107	1.111	1.120	1.127	1.137	1.142	1.153	1.160	1.171	1.177	1.188	1.196	1.207	1.213	1.224	1.232	1.244
Four-Quarter Moving Average Percent Change	1.9	1.9	1.9	2.0	2.3	2.7	2.9	2.9	2.8	2.8	2.9	2.9	3.0	3.0	3.0	3.0	3.0	3.1	3.1	3.1
2010-based Inpatient Hospital Capital:																				
Index Levels	1.038	1.042	1.046	1.049	1.054	1.058	1.062	1.065	1.071	1.075	1.080	1.084	1.089	1.094	1.099	1.104	1.110	1.115	1.120	1.125
Four-Quarter Moving Average Percent Change	1.2	1.3	1.3	1.3	1.4	1.4	1.5	1.5	1.5	1.6	1.6	1.7	1.7	1.7	1.8	1.8	1.8	1.9	1.9	1.9
2010-based Skilled Nursing Facility:																				
Index Levels	1.062	1.071	1.079	1.086	1.090	1.099	1.106	1.112	1.117	1.127	1.134	1.142	1.148	1.159	1.167	1.176	1.182	1.193	1.201	1.210
Four-Quarter Moving Average Percent Change	1.7	1.6	1.6	1.7	2.0	2.3	2.5	2.5	2.5	2.5	2.5	2.6	2.6	2.7	2.8	2.9	2.9	3.0	3.0	3.0
2010-based Home Health:																				
Index Levels	1.060	1.064	1.071	1.079	1.084	1.093	1.099	1.108	1.113	1.124	1.131	1.141	1.147	1.158	1.166	1.175	1.182	1.193	1.201	1.210
Four-Quarter Moving Average Percent Change	1.6	1.6	1.7	1.7	1.9	2.2	2.4	2.6	2.7	2.7	2.8	2.9	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
2008-based Rehabilitation, Psychiatric, and Long Term Care Hospitals with Capital:																				
Index Levels	1.131	1.140	1.149	1.160	1.166	1.175	1.182	1.193	1.199	1.210	1.218	1.229	1.236	1.247	1.255	1.267	1.274	1.286	1.294	1.306
Four-Quarter Moving Average Percent Change	2.0	2.0	1.9	2.0	2.3	2.6	2.8	2.9	2.9	2.9	2.9	3.0	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1
2009-based Long Term Care Hospitals with Capital:																				
Index Levels	1.105	1.116	1.125	1.135	1.140	1.149	1.156	1.166	1.172	1.183	1.190	1.201	1.207	1.218	1.226	1.237	1.244	1.255	1.263	1.274
Four-Quarter Moving Average Percent Change	2.2	2.0	2.0	2.1	2.4	2.7	2.9	2.9	2.8	2.8	2.9	2.9	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
2008-based End Stage Renal Disease:																				
Index Levels	1.160	1.182	1.188	1.198	1.203	1.216	1.222	1.232	1.237	1.251	1.258	1.268	1.274	1.287	1.296	1.306	1.312	1.326	1.334	1.343
Four-Quarter Moving Average Percent Change	3.0	2.7	2.3	2.2	2.6	2.8	3.0	3.1	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	3.0	3.0	3.0	3.0
2006-based Medicare Economic Index:																				
Index Levels	1.150	1.156	1.163	1.171	1.176	1.186	1.192	1.200	1.205	1.217	1.224	1.233	1.239	1.251	1.259	1.268	1.274	1.286	1.294	1.303
Four-Quarter Moving Average Percent Change	0.8	0.9	0.9	1.1	1.3	1.6	1.7	2.0	2.0	2.0	2.1	2.1	2.2	2.2	2.3	2.2	2.2	2.2	2.3	2.2

Source: IHS Global Insight 2014Q2 Forecast, Historical Data through 2014Q1; Released by: CMS, OACT, National Health Statistics Group, DNHS@cms.hhs.gov
Note: All market baskets, with the exception of the MEI, do not reflect a productivity adjustment.

9/22/2014

CMS Market Basket

DPH/DMH Hospitals

	2013Q4	2014Q1	2014Q2	2014Q3	AVERAGE	
	1.079	1.087	1.096	1.107	1.092	% INC
SFY 2015	2014Q4	2015Q1	2015Q2	2015Q3		
	1.111	1.120	1.127	1.137	1.124	2.88%
SFY 2016	2015Q4	2016Q1	2016Q2	2016Q3		
	1.142	1.153	1.160	1.171	1.157	2.91%
SFY 2017	2016Q4	2017Q1	2017Q2	2017Q3		
	1.177	1.188	1.196	1.207	1.192	3.07%
SFY 2018	2017Q4	2018Q1	2018Q2	2018Q3		
	1.213	1.224	1.232	1.244	1.228	3.04%

Exhibit 9: Emergency Services Payroll Projection
Brockton Multi Service Center
Fiscal Year 2016

description	fte	annual_rt
Administrative Assistant I Total	**1.00**	**55,223**
Clinical Social Worker (A/B) Total	**11.00**	**724,677**
Clinical Social Worker (C) Total	**3.75**	**298,822**
Clinical Social Worker (D) Total	**3.00**	**246,778**
Community Psychiatric Mh Nurse Total	**1.00**	**103,163**
Human Services Coord (A/B) Total	**1.00**	**65,817**
Human Services Coordinator (C) Total	**15.60**	**1,029,443**
Licensed Practical Nurse II Total	**7.00**	**349,635**
Mental Health Coordinator I Total	**10.70**	**504,561**
Mental Health Worker I Total	**5.00**	**184,791**
Mental Health Worker II Total	**5.00**	**192,459**
Psychologist IV Total	**1.00**	**123,639**
Registered Nurse II Total	**8.80**	**798,732**
Registered Nurse IV Total	**1.00**	**88,121**
Registered Nurse V Total	**1.00**	**112,229**
Grand Total	**75.85**	**4,878,090**

Fiscal Year 2014 Payroll - Source dbo.Labor_History table - Units 5410, 5330 Sub_Units 00R2, 00AO and 00YA

title_description	A01	A06	A07	A08	AA1	Diff %	Other %	Fringe Eligible %
Administrative Assistant I	54,753					0.00%	0.00%	100.00%
Clinical Social Worker (A/B)	681,802		15,329	37,012		2.25%	5.43%	102.25%
Clinical Social Worker (C)	285,760	2,415	2,847	57,411		1.00%	20.94%	101.00%
Clinical Social Worker (D)	229,558	4,500	51	94,322		0.02%	43.05%	100.02%
Community Psychiatric Mh Nurse	98,847		4,146	9,121		4.19%	9.23%	104.19%
Human Services Coord (A/B)	63,849		210	5,385	780	0.33%	9.65%	101.55%
Human Services Coordinator (C)	956,279		21,580	90,225	22,479	2.26%	11.79%	104.61%
Licensed Practical Nurse II	236,136		10,207	15,008	20,465	4.32%	15.02%	112.99%
Mental Health Coordinator I	391,139		7,759	21,951	1,559	1.98%	6.01%	102.38%
Mental Health Worker I	179,209		9,724	19,372		5.43%	10.81%	105.43%
Mental Health Worker II	162,201		5,737	36,413		3.54%	22.45%	103.54%
Psychologist IV	116,962	1,170	874	37,557		0.75%	33.11%	100.75%
Registered Nurse II	664,344		27,508	56,980	3,543	4.14%	9.11%	104.67%
Registered Nurse IV	71,691		411	10	678	0.57%	0.96%	101.52%
Registered Nurse V	106,228		615	16,500		0.58%	15.53%	100.58%

Total Estimated Salary Costs

					27.27%	1.59%
title_description	FTE	Base Pay *	Other Pay	Annual Wage	Fringe Benefit	Payroll Tax
Administrative Assistant I	1.00	55,223.22	-	55,223	15,059	878
Clinical Social Worker (A/B)	11.00	724,677.20	16,293	764,016	202,063	12,407
Clinical Social Worker (C)	3.75	298,821.90	2,977	361,383	82,301	5,793
Clinical Social Worker (D)	3.00	246,778.22	55	353,013	67,311	5,614
Community Psychiatric Mh Nurse	1.00	103,163.06	4,327	112,682	29,313	1,860
Human Services Coord (A/B)	1.00	65,816.66	216	72,171	18,226	1,151
Human Services Coordinator (C)	15.60	1,029,443.43	23,231	1,150,770	293,663	18,667
Licensed Practical Nurse II	7.00	349,635.26	15,113	402,158	107,730	6,635
Mental Health Coordinator I	10.70	504,560.68	10,008	534,888	140,872	8,664
Mental Health Worker I	5.00	184,790.58	10,027	204,766	53,127	3,415
Mental Health Worker II	5.00	192,458.76	6,807	235,665	54,340	3,855
Psychologist IV	1.00	123,638.84	924	164,576	33,968	2,631
Registered Nurse II	8.80	798,732.28	33,072	871,498	227,995	14,383
Registered Nurse IV	1.00	88,121.28	505	88,967	24,396	1,423
Registered Nurse V	1.00	112,229.00	650	129,661	30,782	2,072
Totals	**75.85**	**4,878,090**	**124,206**	**5,501,439**	**1,381,145**	**89,448**

*Basic Pay is all payroll less differential pay. Overtime pay is estimated based on prior year's and is included.

Exhibit 10: BMSC FY14 Uniform Financial Report

ORGANIZATION: Brockton Multi-Service Center — **ORGANIZATION SUPPLEMENTAL INFORMATION SCHEDULE A - Unaudited** — **FY END:** 6/30/2014 — **FEIN:** 946002282

REVENUE	Total Organization	Admin.(M&G)	Fund Raising	Total All Prog
1R Contributions, Gifts, Legacies, Bequests				
2R Gov. In-Kind/Capital Budget		XXXXXXXXXX	XXXXXXXXXX	
3R Private IN-Kind				
4R **Total Contributions and In-Kind**				
5R Mass Gov. Grant		XXXXXXXXXX	XXXXXXXXXX	
6R Other Grant (exclud. Fed Direct)				
7R **Total Grants**				
8R Dept. of Mental Health (DMH)		XXXXXXXXXX	XXXXXXXXXX	
9R Dept of Developmental Services(DDS/DMR)		XXXXXXXXXX	XXXXXXXXXX	
10R Dept. of Public Health (DPH)		XXXXXXXXXX	XXXXXXXXXX	
11R Dept of Children and Families (DCF/DSS)		XXXXXXXXXX	XXXXXXXXXX	
12R Dept. of Transitional Assist (DTA/WEL)		XXXXXXXXXX	XXXXXXXXXX	
13R Dept. of Youth Services (DYS)		XXXXXXXXXX	XXXXXXXXXX	
14R Health Care Fin & Policy (HCF)-Contract		XXXXXXXXXX	XXXXXXXXXX	
15R Health Care Fin & Policy (HCF)-UCP		XXXXXXXXXX	XXXXXXXXXX	
16R MA. Comm. For the Blind (MCB)		XXXXXXXXXX	XXXXXXXXXX	
17R MA. Comm. for Deaf & H H (MCD)		XXXXXXXXXX	XXXXXXXXXX	
18R MA. Rehabilitation Commission (MRC)		XXXXXXXXXX	XXXXXXXXXX	
19R MA. Off. for Refugees & Immigr.(ORI)		XXXXXXXXXX	XXXXXXXXXX	
20R Dept of Early Educ. & Care (EEC)-Contract		XXXXXXXXXX	XXXXXXXXXX	
21R Dept of Early Educ. & Care (EEC)-Voucher		XXXXXXXXXX	XXXXXXXXXX	
22R Dept of Correction (DOC)		XXXXXXXXXX	XXXXXXXXXX	
23R Dept. of Elementary & Secondary Educ. (DOE)		XXXXXXXXXX	XXXXXXXXXX	
24R Parole Board (PAR)		XXXXXXXXXX	XXXXXXXXXX	
25R Veteran's Services (VET)		XXXXXXXXXX	XXXXXXXXXX	
26R Ex. Off. of Elder Affairs (ELD)		XXXXXXXXXX	XXXXXXXXXX	
27R Div of Housing & Community Develop(OCD)		XXXXXXXXXX	XXXXXXXXXX	
28R POS Subcontract		XXXXXXXXXX	XXXXXXXXXX	
29R Other Mass. State Agency POS		XXXXXXXXXX	XXXXXXXXXX	
30R Mass State Agency Non - POS		XXXXXXXXXX	XXXXXXXXXX	
31R Mass. Local Govt/Quasi-Govt. Entities		XXXXXXXXXX	XXXXXXXXXX	
32R Non-Mass. State/Local Government		XXXXXXXXXX	XXXXXXXXXX	
33R Direct Federal Grants/Contracts		XXXXXXXXXX	XXXXXXXXXX	
34R Medicaid - Direct Payments	2,351,646	XXXXXXXXXX	XXXXXXXXXX	2,351,646
35R Medicaid - MBHP Subcontract		XXXXXXXXXX	XXXXXXXXXX	
36R Medicare	3,353	XXXXXXXXXX	XXXXXXXXXX	3,353
37R Mass. Govt. Client Stipends		XXXXXXXXXX	XXXXXXXXXX	
38R Client Resources		XXXXXXXXXX	XXXXXXXXXX	
39R Mass. Publicly sponsored client offsets		XXXXXXXXXX	XXXXXXXXXX	
40R Other Publicly sponsored client offsets		XXXXXXXXXX	XXXXXXXXXX	
41R Private Client Fees (excluding 3rd Pty)	368,210	XXXXXXXXXX	XXXXXXXXXX	368,210
42R Private Client 3rd Pty/other offsets	350,267	XXXXXXXXXX	XXXXXXXXXX	350,267
43R **Total Assistance and Fees**	3,073,476	XXXXXXXXXX	XXXXXXXXXX	3,073,476
44R Federated Fundraising				
45R Commercial Activities				
46R Non-Charitable Revenue				
47R Investment Revenue				
48R Other Revenue				
49R Allocated Admin (M&G) Revenue	XXXXXXXXXX			
50R Released Net Assets-Program				
51R Released Net Assets-Equipment				
52R Released Net Assets-Time				
53R **TOTAL REVENUE**	3,073,476			3,073,476
54R **TOTAL EXPENSE = 56E**	11,878,748			11,878,748
55R **OPERATING RESULTS**	(8,805,272)			(8,805,272)

EXPENSE	Total Organization FTE	Total Organization Expense	Admin (M&G) FTE	Admin (M&G) Expense	Fund Raising FTE	Fund Raising Expense	Total All Programs FTE	Total All Programs Expense
1E **Total Direct Prog.Staff FTE/Exp 101-138**	85.26	6,209,494	XXXX	XXXXXXXXXX	XXXX	XXXXXXXXXX	85.26	6,209,494
2E Chief Executive Officer - FTE/Exp.								
3E Chief Financial Officer - FTE/Exp.								
4E Acctng/Clerical/Support FTE/Expense	8.81	502,514	8.81	502,514				
5E Admin Maint/House-Grndskeeping FTE/Exp	9.79	302,654	9.79	302,654				
6E **Total Admin Employee FTE/Expense 410**	18.60	805,169	18.60	805,169				
7E Commercial Products & Svs/Mktng FTE/Exp					XXXX	XXXXXXXXXX		
8E **Total FTE/Salary/Wages**	103.86	7,014,662	18.60	805,169			85.26	6,209,494
9E Payroll Taxes 150		102,172		12,292				89,880
10E Fringe Benefits 151		1,696,303		202,558				1,492,745
11E Accrual Adjustments								
12E **Total Employee Compensation & Rel. Exp.**		8,812,137		1,020,019				7,792,118
13E Facility and Prog. Equip Expenses 301, 390		2,049		201				1,848
14E Facility & Prog. Equip. Depreciation 301		63,707		63,707				
15E Facility Operation/Maint./Furn.390		267,962		264,969				2,993
16E Facility General Liability Insurance 390								
17E **Total Occupancy**		333,719		328,877				4,841
18E Direct Care Consultant 201								
19E Temporary Help 202								
20E Clients and Caregivers Reimb./Stipends 203				XXXXXXXXXX		XXXXXXXXXX		
21E Subcontracted Direct Care 206		1,441,075		XXXXXXXXXX		XXXXXXXXXX		1,441,075
22E Staff Training 204								
23E Staff Mileage / Travel 205		60,078		4,130				55,948
24E Meals 207								
25E Client Transportation 208				XXXXXXXXXX		XXXXXXXXXX		
26E Vehicle Expenses 208		10,091		10,091				
27E Vehicle Depreciation 208								
28E Incidental Medical /Medicine/Pharmacy 209		167,313		XXXXXXXXXX		XXXXXXXXXX		167,313
29E Client Personal Allowances 211				XXXXXXXXXX		XXXXXXXXXX		
30E Provision Material Goods/Svs./Benefits 212				XXXXXXXXXX		XXXXXXXXXX		
31E Direct Client Wages 214				XXXXXXXXXX		XXXXXXXXXX		
32E Other Commercial Prod. & Svs. 214								
33E Program Supplies & Materials 215		44,806		XXXXXXXXXX		XXXXXXXXXX		44,806
34E Non Charitable Expenses								
35E Other Expense		286		286				
36E **Total Other Program Expense**		1,723,650		14,508				1,709,142
37E Management Fees 410		977,344		977,344				XXXXXXXXX
38E Fundraising Fees 410				XXXXXXXXXX				XXXXXXXXX
39E Legal Fees 410								XXXXXXXXX
40E Audit Fees 410								XXXXXXXXX
41E Management Consultant 410								XXXXXXXXX
42E Other Professional Fees & Other Admin. Expenses 410								
43E Leased Office/Program Office Equip.410,390		31,899		24,693				7,206
44E Office Equipment Depreciation 410								
45E Admin. Vehicle Expenses 410								XXXXXXXXX
46E Admin. Vehicle Depreciation 410								XXXXXXXXX
47E Directors & Officers Insurance 410								XXXXXXXXX
48E Program Support 216				XXXXXXXXX				
49E Professional Insurance 410								
50E Working Capital Interest 410								
51E **Total Direct Administrative Expense**		1,009,243		1,002,037				7,206
52E Admin (M&G) Reporting Center Allocation		XXXXXXXXX		(2,365,411)				2,365,411
53E **Total Reimbursable & Fundraising Expense**		11,878,748						11,878,748
54E Direct State/Federal Non-Reimbursable Expense						XXXXXXXXX		
55E Allocation of State/Fed Non-Reimbursable Expense		XXXXXXXXX						
56E **TOTAL EXPENSE = 56R**		11,878,748						11,878,748

NON-REIMBURSABLE EXPENSE DETAIL — *Note to Readers:* Please see Schedule B Note to Readers regarding appropriate Non-Reimbursable Exp.

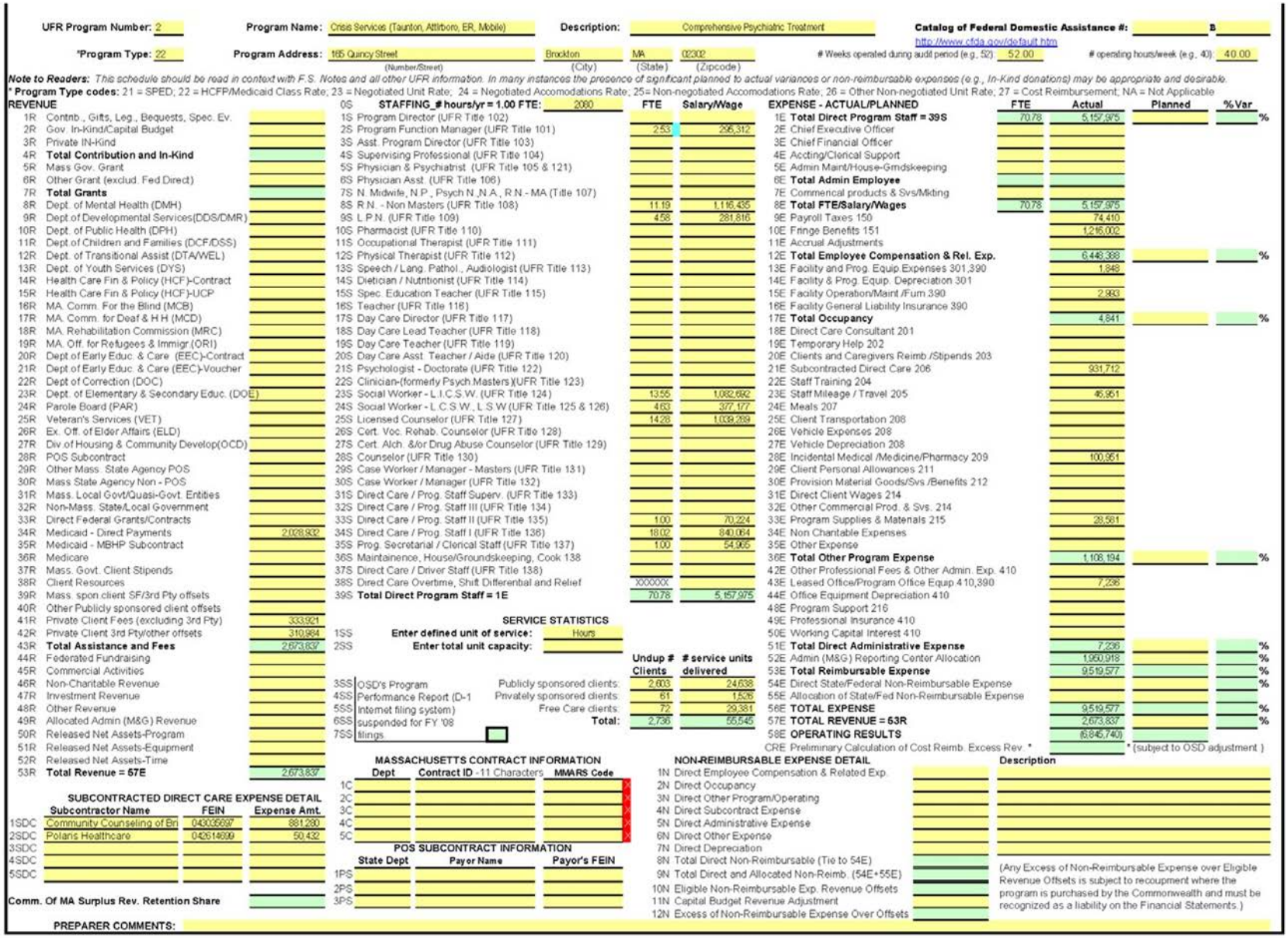
1N Direct Employee Compensation & Related Exp.			XXXXXXXXX	
2N Direct Occupancy			XXXXXXXXX	
3N Direct Other Program/Operating			XXXXXXXXX	
4N Direct Subcontract Expense			XXXXXXXXX	
5N Direct Administrative Expense			XXXXXXXXX	
6N Direct Other Expense			XXXXXXXXX	
7N Direct Depreciation			XXXXXXXXX	
8N Total Direct Non-Reimbursable (must tie to 54E)			XXXXXXXXX	
9N Total Direct and Allocated Non-Reimbursable (54E+55E)			XXXXXXXXX	
10N Eligible Non-Reimb./Fundraising Exp. Revenue Offsets			XXXXXXXXX	
11N Capital Budget Revenue Adjustments			XXXXXXXXX	
12N Excess of Non-Reimb./Fundraising Expense over Offsets			XXXXXXXXX	
Description of Admin (M&G) Direct Non-Reimbursable Exp.				

COMPENSATION DISCLOSURE *Enter all compensation (salary, benefit packages, vehicles, consultant payments, loans, etc.) from the entity & its related parties/affiliates to organization principals. Attach schedule of non-salary items.*

Name & Title	Reporting Entity Compensation Salary	Reporting Entity Compensation Other	Compensation from Other Entities Salary	Compensation from Other Entities Other
1C				
2C				
3C				
4C				
5C				

MA. Surplus Revenue Retention	Starting Balance	Expended Amount	Accrual Amount	Liability Amt.
Prior Year Ma. Revenue			#DIV/0!	#DIV/0!

Comm. of MA cost reimbursement overbilling (preliminary calc. subject to adjustment)



UFR Program Number: 2 | Program Name: Crisis Services (Taunton, Attlboro, ER, Mobile) | Description: Comprehensive Psychiatric Treatment | Catalog of Federal Domestic Assistance #: | B
http://www.cfda.gov/default.htm
*Program Type: 22 | Program Address: 165 Quincy Street (Number/Street) | Brockton (City) | MA (State) | 02302 (Zipcode) | # Weeks operated during audit period (e.g., 52): 52.00 | # operating hours/week (e.g., 40): 40.00

Note to Readers: *This schedule should be read in context with F.S. Notes and all other UFR information. In many instances the presence of significant planned to actual variances or non-reimbursable expenses (e.g., In-Kind donations) may be appropriate and desirable.*
* **Program Type codes:** 21 = SPED; 22 = HCFP/Medicaid Class Rate; 23 = Negotiated Unit Rate; 24 = Negotiated Accomodations Rate; 25= Non-negotiated Accomodations Rate; 26 = Other Non-negotiated Unit Rate; 27 = Cost Reimbursement; NA = Not Applicable

REVENUE

1R	Contrib., Gifts, Leg., Bequests, Spec. Ev.	
2R	Gov. In-Kind/Capital Budget	
3R	Private IN-Kind	
4R	**Total Contribution and In-Kind**	
5R	Mass Gov. Grant	
6R	Other Grant (exclud. Fed Direct)	
7R	**Total Grants**	
8R	Dept. of Mental Health (DMH)	
9R	Dept.of Developmental Services(DDS/DMR)	
10R	Dept. of Public Health (DPH)	
11R	Dept.of Children and Families (DCF/DSS)	
12R	Dept. of Transitional Assist (DTA/WEL)	
13R	Dept. of Youth Services (DYS)	
14R	Health Care Fin & Policy (HCF)-Contract	
15R	Health Care Fin & Policy (HCF)-UCP	
16R	MA. Comm. For the Blind (MCB)	
17R	MA. Comm. for Deaf & H H (MCD)	
18R	MA. Rehabilitation Commission (MRC)	
19R	MA. Off. for Refugees & Immigr.(ORI)	
20R	Dept of Early Educ. & Care (EEC)-Contract	
21R	Dept of Early Educ. & Care (EEC)-Voucher	
22R	Dept of Correction (DOC)	
23R	Dept. of Elementary & Secondary Educ. (DOE)	
24R	Parole Board (PAR)	
25R	Veteran's Services (VET)	
26R	Ex. Off. of Elder Affairs (ELD)	
27R	Div.of Housing & Community Develop(OCD)	
28R	POS Subcontract	
29R	Other Mass. State Agency POS	
30R	Mass State Agency Non - POS	
31R	Mass. Local Govt/Quasi-Govt. Entities	
32R	Non-Mass. State/Local Government	
33R	Direct Federal Grants/Contracts	
34R	Medicaid - Direct Payments	2,028,932
35R	Medicaid - MBHP Subcontract	
36R	Medicare	
37R	Mass. Govt. Client Stipends	
38R	Client Resources	
39R	Mass. spon.client SF/3rd Pty offsets	
40R	Other Publicly sponsored client offsets	
41R	Private Client Fees (excluding 3rd Pty)	333,921
42R	Private Client 3rd Pty/other offsets	310,984
43R	**Total Assistance and Fees**	2,673,837
44R	Federated Fundraising	
45R	Commercial Activities	
46R	Non-Charitable Revenue	
47R	Investment Revenue	
48R	Other Revenue	
49R	Allocated Admin (M&G) Revenue	
50R	Released Net Assets-Program	
51R	Released Net Assets-Equipment	
52R	Released Net Assets-Time	
53R	**Total Revenue = 57E**	2,673,837

SUBCONTRACTED DIRECT CARE EXPENSE DETAIL

	Subcontractor Name	FEIN	Expense Amt.
1SDC	Community Counseling of Bri	043005697	881,280
2SDC	Polaris Healthcare	042614699	50,432
3SDC			
4SDC			
5SDC			

Comm. Of MA Surplus Rev. Retention Share

STAFFING_# hours/yr = 1.00 FTE: 2080

		FTE	Salary/Wage
1S	Program Director (UFR Title 102)		
2S	Program Function Manager (UFR Title 101)	2.53	296,312
3S	Asst. Program Director (UFR Title 103)		
4S	Supervising Professional (UFR Title 104)		
5S	Physician & Psychiatrist (UFR Title 105 & 121)		
6S	Physician Asst. (UFR Title 106)		
7S	N. Midwife, N.P., Psych N.,N.A., R.N.- MA (Title 107)		
8S	R.N. - Non Masters (UFR Title 108)	11.19	1,116,435
9S	L.P.N. (UFR Title 109)	4.58	281,816
10S	Pharmacist (UFR Title 110)		
11S	Occupational Therapist (UFR Title 111)		
12S	Physical Therapist (UFR Title 112)		
13S	Speech / Lang. Pathol., Audiologist (UFR Title 113)		
14S	Dietician / Nutritionist (UFR Title 114)		
15S	Spec. Education Teacher (UFR Title 115)		
16S	Teacher (UFR Title 116)		
17S	Day Care Director (UFR Title 117)		
18S	Day Care Lead Teacher (UFR Title 118)		
19S	Day Care Teacher (UFR Title 119)		
20S	Day Care Asst. Teacher / Aide (UFR Title 120)		
21S	Psychologist - Doctorate (UFR Title 122)		
22S	Clinician-(formerly Psych.Masters)(UFR Title 123)		
23S	Social Worker - L.I.C.S.W. (UFR Title 124)	13.55	1,082,692
24S	Social Worker - L.C.S.W., L.S.W.(UFR Title 125 & 126)	4.63	377,177
25S	Licensed Counselor (UFR Title 127)	14.28	1,039,289
26S	Cert. Voc. Rehab. Counselor (UFR Title 128)		
27S	Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)		
28S	Counselor (UFR Title 130)		
29S	Case Worker / Manager - Masters (UFR Title 131)		
30S	Case Worker / Manager (UFR Title 132)		
31S	Direct Care / Prog. Staff Superv. (UFR Title 133)		
32S	Direct Care / Prog. Staff III (UFR Title 134)		
33S	Direct Care / Prog. Staff II (UFR Title 135)	1.00	70,224
34S	Direct Care / Prog. Staff I (UFR Title 136)	18.02	840,064
35S	Prog. Secretarial / Clerical Staff (UFR Title 137)	1.00	54,905
36S	Maintainence, House/Groundskeeping, Cook 138		
37S	Direct Care / Driver Staff (UFR Title 138)		
38S	Direct Care Overtime, Shift Differential and Relief	XXXXXX	
39S	**Total Direct Program Staff = 1E**	70.78	5,157,975

SERVICE STATISTICS

1SS	**Enter defined unit of service:**	Hours
2SS	**Enter total unit capacity:**	

		Undup # Clients	# service units delivered
3SS	OSD's Program	2,603	24,638
4SS	Performance Report (D-1	61	1,526
5SS	Internet filing system)	72	29,381
6SS	suspended for FY '08	2,736	55,545
7SS	filings		

Publicly sponsored clients:
Privately sponsored clients:
Free Care clients:
Total:

MASSACHUSETTS CONTRACT INFORMATION

	Dept	Contract ID - 11 Characters	MMARS Code
1C			
2C			
3C			
4C			
5C			

POS SUBCONTRACT INFORMATION

	State Dept	Payor Name	Payor's FEIN
1PS			
2PS			
3PS			

EXPENSE - ACTUAL/PLANNED

		FTE	Actual	Planned	%Var
1E	**Total Direct Program Staff = 39S**	70.78	5,157,975		%
2E	Chief Executive Officer				
3E	Chief Financial Officer				
4E	Accting/Clerical Support				
5E	Admin Maint/House-Grndskeeping				
6E	**Total Admin Employee**				
7E	Commercial products & Svs/Mkting				
8E	**Total FTE/Salary/Wages**	70.78	5,157,975		
9E	Payroll Taxes 150		74,410		
10E	Fringe Benefits 151		1,216,002		
11E	Accrual Adjustments				
12E	**Total Employee Compensation & Rel. Exp.**		6,448,388		%
13E	Facility and Prog. Equip.Expenses 301,390		1,848		
14E	Facility & Prog. Equip. Depreciation 301				
15E	Facility Operation/Maint./Furn.390		2,993		
16E	Facility General Liability Insurance 390				
17E	**Total Occupancy**		4,841		%
18E	Direct Care Consultant 201				
19E	Temporary Help 202				
20E	Clients and Caregivers Reimb./Stipends 203				
21E	Subcontracted Direct Care 206		931,712		
22E	Staff Training 204				
23E	Staff Mileage / Travel 205		46,951		
24E	Meals 207				
25E	Client Transportation 208				
26E	Vehicle Expenses 208				
27E	Vehicle Depreciation 208				
28E	Incidental Medical /Medicine/Pharmacy 209		100,951		
29E	Client Personal Allowances 211				
30E	Provision Material Goods/Svs./Benefits 212				
31E	Direct Client Wages 214				
32E	Other Commercial Prod. & Svs. 214				
33E	Program Supplies & Materials 215		28,581		
34E	Non Charitable Expenses				
35E	Other Expense				
36E	**Total Other Program Expense**		1,108,194		%
42E	Other Professional Fees & Other Admin. Exp. 410				
43E	Leased Office/Program Office Equip 410,390		7,296		
44E	Office Equipment Depreciation 410				
48E	Program Support 216				
49E	Professional Insurance 410				
50E	Working Capital Interest 410				
51E	**Total Direct Administrative Expense**		7,296		%
52E	Admin (M&G) Reporting Center Allocation		1,960,918		%
53E	**Total Reimbursable Expense**		9,519,577		%
54E	Direct State/Federal Non-Reimbursable Expense				%
55E	Allocation of State/Fed Non-Reimbursable Expense				
56E	**TOTAL EXPENSE**		9,519,577		%
57E	**TOTAL REVENUE = 53R**		2,673,837		%
58E	**OPERATING RESULTS**		(6,845,740)		
CRE	Preliminary Calculation of Cost Reimb. Excess Rev. *				* (subject to OSD adjustment)

NON-REIMBURSABLE EXPENSE DETAIL

		Description
1N	Direct Employee Compensation & Related Exp.	
2N	Direct Occupancy	
3N	Direct Other Program/Operating	
4N	Direct Subcontract Expense	
5N	Direct Administrative Expense	
6N	Direct Other Expense	
7N	Direct Depreciation	
8N	Total Direct Non-Reimbursable (Tie to 54E)	
9N	Total Direct and Allocated Non-Reimb. (54E+55E)	
10N	Eligible Non-Reimbursable Exp. Revenue Offsets	
11N	Capital Budget Revenue Adjustment	
12N	Excess of Non-Reimbursable Expense Over Offsets	

(Any Excess of Non-Reimbursable Expense over Eligible Revenue Offsets is subject to recoupment where the program is purchased by the Commonwealth and must be recognized as a liability on the Financial Statements.)

PREPARER COMMENTS:

Corrigan Mental Health Center Emergency Services Program (ESP) Cost Forms

APPENDIX C (Form 2)

In-House Cost Estimate

FULLY ALLOCATED COST

	Fiscal Year 2016	Avoidable Cost	Fiscal Year 2017	Avoidable Cost	Fiscal Year 2018	Avoidable Cost	Total	Total Avoidable Cost
Direct Cost								
Personnel Cost	$ 3,243,654.64	$ 3,243,654.64	$ 3,343,222.08	$ 3,343,222.08	$ 3,444,893.05	$ 3,444,893.05	$ 10,031,769.77	$ 10,031,769.77
Material and Supply Costs	$ 1,234.35	$ 1,234.35	$ 1,272.24	$ 1,272.24	$ 1,310.93	$ 1,310.93	$ 3,817.53	$ 3,817.53
Other Direct Costs								$ -
Rent	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Depreciation	$ 7,454.84	$ 7,454.84	$ 7,683.67	$ 7,683.67	$ 7,917.34	$ 7,917.34	$ 23,055.85	$ 23,055.85
Maintenance	$ 22,487.51	$ 22,487.51	$ 23,177.78	$ 23,177.78	$ 23,882.64	$ 23,882.64	$ 69,547.93	$ 69,547.93
Utilities	$ 76,429.45	$ 76,429.45	$ 78,775.54	$ 78,775.54	$ 81,171.19	$ 81,171.19	$ 236,376.18	$ 236,376.18
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ 972,125.16	$ 972,125.16	$ 1,001,965.57	$ 1,001,965.57	$ 1,032,436.42	$ 1,032,436.42	$ 3,006,527.15	$ 3,006,527.15
Indirect Costs								
Departmental	$ 127,256.96	$ -	$ 131,163.25	$ -	$ 135,152.06	$ -	$ 393,572.27	$ -
Executive Office	$ 46,405.39	$ -	$ 47,829.86	$ -	$ 49,284.41	$ -	$ 143,519.66	$ -
Central Services	$ 19,929.80	$ -	$ 20,541.57	$ -	$ 21,166.26	$ -	$ 61,637.62	$ -
Total In-House Costs	**$ 4,516,978.10**	**$ 4,323,385.95**	**$ 4,655,631.56**	**$ 4,456,096.89**	**$ 4,797,214.31**	**$ 4,591,611.58**	**$ 13,969,823.97**	**$ 13,371,094.43**
Less Total Revenue	$ 611,308.06	$ 611,308.06	$ 630,072.82	$ 630,072.82	$ 649,234.01	$ 649,234.01	$ 1,890,614.89	$ 1,890,614.89
Total Costs	$ 3,905,670.04	$ 3,712,077.89	$ 4,025,558.74	$ 3,826,024.07	$ 4,147,980.31	$ 3,942,377.57	$ 12,079,209.08	$ 11,480,479.54

APPENDIX C (Form 2a)

Summary In-House Cost Estimate

	Current Operating Budget	Adjustments	Revised Total Cost Period A	Adjustments	Revised Total Cost Period B	Adjustments	Revised Total Cost Period C
Direct Cost							
		2.91%		3.07%		3.04%	
Personnel Wages							
Clinical Social Worker (A/B)	$ 181,748.54	$ 5,296.79	$ 187,045.32	$ 5,741.56	$ 192,786.88	$ 5,862.86	$ 198,649.74
Clinical Social Worker (C)	$ 196,534.08	$ 5,727.69	$ 202,261.76	$ 6,208.64	$ 208,470.41	$ 6,339.81	$ 214,810.21
Clinical Social Worker (D)	$ 100,236.33	$ 2,921.24	$ 103,157.56	$ 3,166.53	$ 106,324.10	$ 3,233.43	$ 109,557.53
Human Services Coordinator (C)	$1,293,386.92	$ 37,693.81	$ 1,331,080.73	$ 40,858.94	$1,371,939.67	$ 41,722.16	$1,413,661.83
Human Services Coordinator (D)	$ 160,437.67	$ 4,675.71	$ 165,113.39	$ 5,068.33	$ 170,181.72	$ 5,175.41	$ 175,357.13
Licensed Practical Nurse I	$ 403,203.34	$ 11,750.75	$ 414,954.09	$ 12,737.46	$ 427,691.55	$ 13,006.56	$ 440,698.11
Licensed Practical Nurse II	$ 76,441.24	$ 2,227.76	$ 78,669.01	$ 2,414.83	$ 81,083.84	$ 2,465.85	$ 83,549.68
Mental Health Coordinator I	$ 309,283.23	$ 9,013.59	$ 318,296.83	$ 9,770.46	$ 328,067.29	$ 9,976.88	$ 338,044.17
Mental Health Worker I	$ 128,774.80	$ 3,752.95	$ 132,527.75	$ 4,068.08	$ 136,595.83	$ 4,154.03	$ 140,749.86
Psychologist IV	$ 157,360.36	$ 4,586.03	$ 161,946.39	$ 4,971.12	$ 166,917.51	$ 5,076.14	$ 171,993.65
Registered Nurse IV	$ 144,393.66	$ 4,208.14	$ 148,601.80	$ 4,561.49	$ 153,163.29	$ 4,657.86	$ 157,821.15
Materials & Supplies							
Office Supplies	$ 1,199.40	$ 34.95	$ 1,234.35	$ 37.89	$ 1,272.24	$ 38.69	$ 1,310.93
Equipment Purchase	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Direct Costs							
Travel and Other Employee Reimb.	$ 2,125.40	$ 61.94	$ 2,187.34	$ 67.14	$ 2,254.48	$ 68.56	$ 2,323.05
Payroll Taxes	$ 39,923.42	$ 1,163.51	$ 41,086.92	$ 1,261.21	$ 42,348.13	$ 1,287.85	$ 43,635.98
Office Equipment Lease	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Depreciation	$ 7,243.73	$ 211.11	$ 7,454.84	$ 228.83	$ 7,683.67	$ 233.67	$ 7,917.34
Administration	$ 268,396.01	$ 7,822.00	$ 276,218.01	$ 8,478.81	$ 284,696.81	$ 8,657.94	$ 293,354.75
Plant Maintenance	$ 21,850.70	$ 636.81	$ 22,487.51	$ 690.28	$ 23,177.78	$ 704.86	$ 23,882.64
Plant Operations	$ 74,265.11	$ 2,164.34	$ 76,429.45	$ 2,346.08	$ 78,775.54	$ 2,395.65	$ 81,171.19
Housekeeping	$ 34,982.04	$ 1,019.50	$ 36,001.54	$ 1,105.11	$ 37,106.64	$ 1,128.45	$ 38,235.10
Contracted Observation Beds	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical Records	$ 221,675.45	$ 6,460.40	$ 228,135.85	$ 7,002.87	$ 235,138.72	$ 7,150.82	$ 242,289.55
Medical Staff	$ 377,494.00	$ 11,001.49	$ 388,495.49	$ 11,925.28	$ 400,420.78	$ 12,177.23	$ 412,598.00
Total Direct Costs	$4,200,955.44	$122,430.51	$ 4,323,385.95	$132,710.94	$4,456,096.89	$135,514.69	$4,591,611.58
Indirect Costs							
Departmental	$ 123,653.27	$ 3,603.69	$ 127,256.96	$ 3,906.29	$ 131,163.25	$ 3,988.82	$ 135,152.06
Executive Office	$ 45,091.28	$ 1,314.12	$ 46,405.39	$ 1,424.46	$ 47,829.86	$ 1,454.56	$ 49,284.41
Central Services	$ 19,365.42	$ 564.38	$ 19,929.80	$ 611.77	$ 20,541.57	$ 624.69	$ 21,166.26
Total Indirect Costs	$ 188,109.97	$ 5,482.18	$ 193,592.15	$ 5,942.52	$ 199,534.67	$ 6,068.06	$ 205,602.73
Total Direct & Indirect Costs	$4,389,065.41	$127,912.70	$ 4,516,978.10	$138,653.46	$4,655,631.56	$141,582.76	$4,797,214.31
Total Revenues	$ 593,996.92	$ 17,311.14	$ 611,308.06	$ 18,764.75	$ 630,072.82	$ 19,161.19	$ 649,234.01
Total Costs	$3,795,068.49	$110,601.55	$ 3,905,670.04	$119,888.70	$4,025,558.74	$122,421.56	$4,147,980.31

APPENDIX C (Form 2b)

Personnel Cost Worksheet

Position Title or Skill	FTEs Required	Annual Wage	Other Pay	Basic Pay	Fringe Benefits	Personnel Cost
Clinical Social Worker (A/B)	1.90	$ 141,521.44	$ 2,277.30	$ 143,798.74	$ 37,949.79	$ 181,748.54
Clinical Social Worker (C)	2.00	$ 154,100.04	$ 2,210.68	$ 156,310.72	$ 40,223.36	$ 196,534.08
Clinical Social Worker (D)	1.00	$ 79,634.31	$ 15.90	$ 79,650.21	$ 20,586.12	$ 100,236.33
Human Services Coordinator (C)	14.30	$ 1,003,517.17	$ 28,105.12	$ 1,031,622.29	$ 261,764.63	$ 1,293,386.92
Human Services Coordinator (D)	1.50	$ 126,645.64	$ 4,904.30	$ 131,549.95	$ 28,887.73	$ 160,437.67
Licensed Practical Nurse I	4.80	$ 314,230.94	$ 8,913.56	$ 323,144.50	$ 80,058.84	$ 403,203.34
Licensed Practical Nurse II	1.00	$ 60,383.25	$ (22.39)	$ 60,360.86	$ 16,080.38	$ 76,441.24
Mental Health Coordinator I	4.60	$ 241,252.68	$ 3,693.71	$ 244,946.39	$ 64,336.84	$ 309,283.23
Mental Health Worker I	3.00	$ 94,603.60	$ 5,935.77	$ 100,539.37	$ 28,235.44	$ 128,774.80
Psychologist IV	1.00	$ 123,638.84	$ 4.09	$ 123,642.93	$ 33,717.43	$ 157,360.36
Registered Nurse IV	1.00	$ 114,611.09	$ 729.68	$ 115,340.77	$ 29,052.90	$ 144,393.66
	36.10	**$2,454,139.01**	**$56,767.71**	**$2,510,906.72**	**$640,893.46**	**$3,151,800.18**

Form 2A Notes

Corrigan Mental Health Center is a facility located at 49 Hillside Street in Fall River, MA. The center primarily services the communities of Assonet, Fall River, Freetown, Somerset, Swansea and Westport. The center offers a number of behavioral health services in addition to the ESP programs Community Based Location and Mobile Crisis Intervention program.

All costs included in this form include only relevant sub-units related to the ESP program.[7]

Direct Costs

Personnel

The *Current Operating Budget*, for the purposes of this report, is assumed as FY15 and as such is derived from the same sources as those outlined in the details related to form 2b, also included in these financial notes. The *Adjustment* column is based on quarterly CMS Market Basket Index Levels between FY15 and FY16. This federally derived adjustment, when applied to the current operating budget produces the form's "Revised Total Cost Period A". Subsequent years are calculated in a similar fashion.

Materials and Supplies

The object classes included in this analysis are those associated with office supplies, including: EE (administrative expense), JJ (programmatic operational services), FF (programmatic facility operational supplies and related expenses), GG (energy costs, utilities and space rental expenses), and N52 (facility infrastructure maintenance and repair tools and supplies) and specifically included object E01 (office and admin supplies). Object codes related to indirect cost recoupment and recreation, religious and social supplies and materials were excluded as they are contemplated directly through another direct cost analysis. A full list of expenses can be found in exhibit 12, Corrigan FY14 Expenses on page 582.

Other Direct Costs

Travel and Other Employee Reimbursements

Costs include those associated with the following object codes: B02 (In-State Travel), B03 (Overtime Meals), and B91 (Employee Reimbursement Accounts Payable Non-tax). Object class AA (state employee compensation) and object D09 (fringe benefit costs recoupment) were excluded as they related to costs previously included in Form 2b. A full list of expenses can be found in exhibit 12, Corrigan FY14 Expenses on page 582.

Payroll Taxes

Payroll taxes collected by the Commonwealth were not netted from the totals of Form 2A Summary of In-House Cost Estimates. This dollar amount (1.59% for FY15 or $160,099 for FY16 after adjustments) represents taxes paid by DMH to the Commonwealth. As the total FTE and salary levels attributed directly to the SE ESP operations of the vendor are not known, it was not possible to identify a corresponding increase or decrease in payroll taxes paid to the Commonwealth by either vendor as a result of the privatization. Therefore a conservative approach was taken to assume that these dollar amounts would be relatively similar and that the overall impact to the Commonwealth would not be material.

[7] These sub-units as typically reported through the programs Uniform Financial Reports and are classified collectively as Crisis Services, their sub-unit codes are 00AO, 00R2, and 00YA

Office Equipment Lease

Although other facilities have costs related to leased office equipment, the Corrigan facility has no expenses related to this category.

Depreciation, Administration, Plant Maintenance, Plant Ops, and Housekeeping

Costs were determined using data from the Corrigan Mental Health Center FY14 Hospital 403 Cost Report as submitted to the Center for Health Information and Analysis, and includes those amounts pertaining to social services that are allocated to ESP. This is provided in exhibit 15 on page 587.

Contracted Observation Beds

There are no expenses allocated to this category for Corrigan Mental Health Center.

Medical Records

Total medical record costs for Corrigan is $177,074. Of this, $163,557 is associated with expenses that are considered fringe eligible costs. Using the current fringe rate of 27.27% an additional $44,602 has been included in *Medical Records* for a total of $221,675. All Medical Record items can be found in exhibit 12, Corrigan FY14 Expenses on page 582.

Medical Staff

All medical costs associated with the operations of the ESP programs at the Corrigan facility were based on data extracted from the Corrigan FY14 Hospital 403 Cost Report found on page 587.[8]

Indirect Costs

All indirect costs including Departmental, Executive Office, and Central Services were calculated using the FY14 Department of Mental Health Cost Allocation Plan dated 11/26/2014.

[8] Schedule XV, Column 17, line 79

Form 2B Notes

FY15 salary data is derived from CY14 salary data (MRS CY14) amounts. “Annual Wage” includes all costs associated with personnel codes A01 (salaries), A06 (stand-by pay), A08 (overtime pay) and AA1 (supplemental salaries) for all applicable program personnel. “Other Pay” includes costs associated with personnel codes A07 (shift differential pay) for all applicable program personnel. “Basic Pay” is the sum of the annual wage and other pay. “Fringe Benefits” includes costs associated with personnel codes A01, A07 and AA1 from CY14 payroll data multiplied by the FY15 Fringe Benefit Rate of 27.27%. “Personnel Costs” includes all applicable basic pay and fringe pay. All personnel cost information can be found in exhibit 14 on page 586.

Form 2A/2B Data Sources

Exhibit	Source	Used in Form	Description
11	FY15 Revenue by Payer	2/2A	Total revenue collected by payer for the facility in FY15
12	Corrigan FY14 Expenses	2A	List of Corrigan expenses for the Crisis sub units, filtered for relevant costs included in Form 2A
13	Allocated Cost Calculation	2A	Total overhead costs and amounts to be allocated to crisis
14	Corrigan ESP Payroll Projection	2B	Total FTE counts and estimated salary costs by position for Corrigan
15	Corrigan Mental Health Center Medicaid 403 Cost Report	2A	Medicaid Cost Report as filed with CHIA for Fiscal Year 2014.

Exhibit 11: FY15 Revenue by Payer

Revenue by Dept. by Payer
Corrigan FY15

NOTE: Medicaid FFP amounts reflect the actual revenue received

Dept	July Billed	July Received	August Billed	August Received	Sept Billed	Sept Received	Oct Billed	Oct Received	Nov Billed	Nov Received	Dec Billed	Dec Received
BRK Crisis												
B/C	5,184.00	1,509.60	287.22	3,437.74	3,195.00	1,568.60	3,492.78	164.80	783.00	-	4,784.78	-
Medicaid	33,837.78	37,632.77	36,645.22	15,679.01	42,230.01	52,604.77	55,610.47	51,490.76	36,596.69	29,127.25	41,494.90	39,742.31
Medicaid FFP		18,816.39		7,839.51		26,302.39		25,745.38		14,563.63		19,871.16
Medicare	11,436.00	1,238.32	13,068.00	3,464.84	16,878.00	1,286.29	11,340.00	3,994.48	19,062.00	3,728.85	13,008.00	3,975.90
Comm	43,266.00	9,261.47	38,154.00	14,714.80	45,615.00	12,496.86	36,948.00	10,286.88	35,757.00	8,493.78	44,946.00	5,947.20
Self/Free	47,439.96	-	48,134.94	-	42,059.09	-	54,431.02	-	54,069.64	-	51,012.58	-
Total	141,163.74	49,642.16	136,289.38	37,296.39	149,977.10	67,956.52	161,822.27	65,936.92	146,268.33	41,349.88	155,246.26	49,665.41
% Received		35%		27%		45%		41%		28%		32%

Dept	Jan Billed	Jan Received	Feb Billed	Feb Received	March Billed	March Received	April Billed	April Received	May Billed	May Received	June Billed	June Received
BRK Crisis												
B/C	921.22	1,547.43	3,519.00	606.40	3,195.00	522.00	684.00	-	1,559.48	-	4,893.52	215.00
Medicaid	43,474.11	36,661.30	48,651.23	39,858.91	41,944.29	46,999.76	36,242.09	21,017.75	39,218.52	44,079.17	33,036.90	13,627.95
Medicaid FFP		18,330.65		19,929.46		23,499.88		10,508.88		22,039.59		6,813.98
Medicare	8,568.00	3,347.56	9,948.00	2,927.74	9,687.00	1,038.41	10,047.00	2,737.33	13,368.00	2,240.76	11,826.00	1,237.28
Comm	27,951.00	16,398.94	33,222.00	6,291.52	38,085.00	12,964.20	33,633.00	5,205.93	36,480.00	14,371.84	32,847.00	8,252.46
Self/Free	54,857.62	-	54,522.00	-	45,168.00	-	59,406.00	-	46,490.62	-	54,406.16	-
Total	135,771.95	57,955.23	149,862.23	49,684.57	138,079.29	61,524.37	140,012.09	28,961.01	137,116.62	60,691.77	137,009.58	23,332.69
% Received		43%		33%		45%		21%		44%		17%

	Total YTD Billed	Total YTD Received
BRK Crisis		
B/C	32,499.00	9,571.57
Medicaid	488,982.21	428,521.71
Medicaid FFP		214,260.86
Medicare	148,236.00	31,217.76
Comm	446,904.00	124,685.88
Self/Free	611,997.63	-
Total	1,728,618.84	593,996.92
% Received		34%

Run Period end: Accounts receivable: INS GRP/INS/ACCT TYPE REPORT

Exhibit 12: Corrigan Community Mental Health Center Expenses
Fiscal Year 2014

budget fiscal year	fiscal year	fiscal period	department	department name	division	division name	district	district name	unit	unit name	sub unit	sub unit name	cash expense amount	appropriation	appropriation name	appropriation type	appropriation type name	fund	object	object name	object class	object class name	activity	activity name	legal name	acceptance date
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	13.95	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		25-Feb-14
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	11.25	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		15-Aug-13
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	3.6	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		28-Jan-14
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	19.25	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		20-May-14
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	114.7	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B91	Employee Reimbursement Accounts Payable -Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		01-Aug-14
2014	2014	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	1.8	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		01-Aug-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	92.25	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		03-Jun-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	32.4	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		31-Dec-13
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	32.4	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		15-Aug-13
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	23.85	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		21-Nov-13
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	86.4	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		26-Sep-13
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	78.3	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		26-Sep-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	667.56	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	E01	Office & Administrative Supplies	EE	ADMINISTRATIVE EXPENSES	3065	COMMUNITY & SCHOOL THERAPEUTIC SUPPORT	W. B MASON CO INC	27-Jun-14
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	26.1	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		28-Jan-14
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	24.3	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		01-Jul-14

2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	95	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	E01	Office & Administrative Supplies	EE	ADMINISTRATIVE EXPENSES	3065	COMMUNITY & SCHOOL THERAPEUTIC SUPPORT	W. B MASON CO INC	25-Jun-14
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	31.5	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		25-Mar-14
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	27	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		11-Mar-14
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	98.1	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		25-Feb-14
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	10.8	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		22-Apr-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	78.3	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		05-Dec-13
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	31.05	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		28-Jan-14
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	16.2	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		24-Oct-13
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	98.5	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		25-Feb-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	26.1	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Dec-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	55.8	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		03-Jun-14
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	29.7	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		25-Feb-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	30.6	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		05-Dec-13
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	17.1	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		26-Sep-13
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	46.8	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		11-Mar-14
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	77.91	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		22-Apr-14
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	62.33	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		24-Oct-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	97.91	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Jun-14

2014	2015	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	9.48	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	E01	Office & Administrative Supplies	EE	ADMINISTRATIVE EXPENSES	3065	COMMUNITY & SCHOOL THERAPEUTIC SUPPORT	W. B MASON CO INC	17-Jul-14
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	31.95	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B91	Employee Reimbursement Accounts Payable -Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		07-Aug-14
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	83.25	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		01-Jul-14
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	54.28	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		24-Oct-13
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	1.8	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		31-Dec-13
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	427.36	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	E01	Office & Administrative Supplies	EE	ADMINISTRATIVE EXPENSES	3065	COMMUNITY & SCHOOL THERAPEUTIC SUPPORT	W. B MASON CO INC	05-Feb-14
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	90	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		03-Jun-14
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	33.3	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		06-May-14
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION FALL RIVER	75.02	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations/subsidiarized	0010	B03	Overtime Meals	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		24-Oct-13
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	7.2	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		31-Dec-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	58.5	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		01-Jul-14
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	11.7	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		07-Nov-13
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	175.5	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B91	Employee Reimbursement Accounts Payable -Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		07-Aug-14
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	28.8	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		26-Sep-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	29.25	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Jun-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	21.6	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Dec-13
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5410	CORRIGAN CMHC	5410	CORRIGAN CMHC	00AO	CORRIGAN DEP	27	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations/subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		20-May-14

Exhibit 13: Allocated Cost Calculation
Corrigan Mental Health Center
Fiscal Year 2014

	Departmental	Executive	Central Services
Allocated to Social Service	175,177	63,880	27,435
Social Service portion allocated to Emergency	117,369	42,800	18,381
Directly Allocated to Emergency	6,284	2,292	984
Total	123,653	45,091	19,365

Administration Cost Allocation Breakdown

	Expense alloc.	% To Total
Total Admin	1,891,980	
Departmental Allocation	512,394	27.08%
Executive Allocation	186,849	9.88%
Central Service Cost	80,246	4.24%
Facility Admin	1,112,490	58.80%
Admin Cost Allocated to Social Work	646,830	

Sources: CHIA FY14 Cost Report, FY14 DMH Home Office Cost Allocation Plan

Exhibit 14: Emergency Services Payroll Projection
Corrigan Mental Health Center
Fiscal Year 2016

Base Salary Information - Source MRS - Through Pay Period 12/13/2014

description	fte	annual_rt
Clinical Social Worker (A/B) Total	**1.90**	**136,886**
Clinical Social Worker (C) Total	**2.00**	**143,779**
Clinical Social Worker (D) Total	**1.00**	**75,474**
Human Services Coordinator (C) Total	**14.30**	**909,719**
Human Services Coordinator (D) Total	**1.50**	**98,452**
Licensed Practical Nurse I Total	**4.80**	**261,065**
Licensed Practical Nurse II Total	**1.00**	**53,562**
Mental Health Coordinator I Total	**4.60**	**228,926**
Mental Health Worker I Total	**3.00**	**97,605**
Psychologist IV Total	**1.00**	**123,639**
Registered Nurse IV Total	**1**	**103,163**
Grand Total	**36.10**	**2,232,270**

Fiscal Year 2014 Payroll - Source dbo.Labor_History table - Units 5410, 5330 Sub_Units 00R2, 00AO and 00YA

title_description	A01	A06	A07	A08	AA1	Diff %	Other %	Fringe Eligible %
Clinical Social Worker (A/B)	130,004	210	2,163	4,193		1.66%	3.39%	101.66%
Clinical Social Worker (C)	131,380	88	2,020	7,963	1,380	1.54%	7.18%	102.59%
Clinical Social Worker (D)	71,221	70	15	3,856		0.02%	5.51%	100.02%
Human Services Coordinator (C)	814,525	1,978	25,164	62,240	19,765	3.09%	10.31%	105.52%
Human Services Coordinator (D)	30,074	53	1,498	7,773	787	4.98%	28.64%	107.60%
Licensed Practical Nurse I	171,295		5,849	19,399	15,485	3.41%	20.36%	112.45%
Licensed Practical Nurse II	23,922		(10)	622	2,424	-0.04%	12.73%	110.09%
Mental Health Coordinator I	167,069		2,696	6,584	2,413	1.61%	5.38%	103.06%
Mental Health Worker I	23,606		1,436	(726)		6.08%	-3.07%	106.08%
Psychologist IV	120,774		4			0.00%	0.00%	100.00%
Registered Nurse IV	15,637		111	1,334	401	0.71%	11.10%	103.27%

Total Estimated Salary Costs

					27.27%	1.59%
title_description	FTE	Base Pay *	Other Pay	Annual Wage	Fringe Benefits	Payroll Tax
Clinical Social Worker (A/B)	1.90	136,886	2,277	141,521	37,950	2,286
Clinical Social Worker (C)	2.00	143,779	2,211	154,100	40,223	2,485
Clinical Social Worker (D)	1.00	75,474	16	79,634	20,586	1,266
Human Services Coordinator (C)	14.30	909,719	28,105	1,003,517	261,765	16,403
Human Services Coordinator (D)	1.50	98,452	4,904	126,646	28,888	2,092
Licensed Practical Nurse I	4.80	261,065	8,914	314,231	80,059	5,138
Licensed Practical Nurse II	1.00	53,562	(22)	60,383	16,080	960
Mental Health Coordinator I	4.60	228,925.58	3,694	241,253	64,337	3,895
Mental Health Worker I	3.00	97,605	5,936	94,604	28,235	1,599
Psychologist IV	1.00	123,639	4	123,639	33,717	1,966
Registered Nurse IV	1.00	103,163	730	114,611	29,053	1,834
	36.10	**2,232,270**	**56,768**	**2,454,139**	**640,893**	**39,923**

*Basic Pay is all payroll less differential pay. Overtime pay is estimated based on prior year's and is included.

Exhibit 15: Corrigan's FY14 Medicaid 403 Cost Report

COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:14 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	2 Direct Exp (Sch IX, Col.13)	3 Allocated Expense	4 Total Exp for Stepdown	5 Bldg and Fixed Deprec	6 Fringe Benefits	7 Adminis-tration
	Overhead						
1	Buildings / Fixed Depreciation	95,481		95,481			
2	Fringe Benefits	1,632,313		1,632,313			
3	Administration	1,767,272	124,708	1,891,980	12,787	111,921	
4	Plant Maintenance / Repairs	243,982	58,354	302,336	1,424	24,897	32,033
5	Plant Operations	552,558	256,095	808,653	17,313	73,876	100,498
6	Laundry and Linen	10,410	4,200	14,610	242		
7	Housekeeping	234,369	135,997	370,366	1,528	47,547	61,915
8	Cafeteria						
9	Dietary Services	511,099	466,432	977,531	12,042	80,895	104,733
10	Maintenance of Personnel						
11	Nursing Administration	505,375	321,343	826,718	1,662	129,286	153,310
12	RN / LPN Education						
13	Medical Staff - Teaching	1,631,640	84,242	1,715,882	1,194	25,746	30,646
14	Post Graduate Medical Education						
15	Central Services & Supplies						
16	Pharmacy	145,523		145,523			
17	Medical Records	179,672	163,522	343,194	3,036	42,422	50,306
18	Medical Care Review	22,787		22,787			
19	Social Services	2,158,654	1,274,290	3,432,944	4,519	522,086	646,830
20	Other Overhead (Specify)						
21	Subtotal Overhead	9,691,135	2,889,183	12,580,318	55,747	1,058,676	1,180,271
	Ancillary Care Services						
22	Surgery						
23	Labor & Delivery						
24	Recovery Room						
25	Anesthesiology	176					
26	Intravenous Therapy						
27	Medical Supplies - Special	78					
28	Drugs - Special						
29	Laboratory	17,243					
30	Blood						
31	Blood Processing / Storage						
32	Electrocardiology (EKG)	108					
33	Cardiac Cath Laboratory						
34	Diagnostic Radiology	143					
35	Therapeutic Radiology						
36	Computerized Tomography						
37	Nuclear Medicine						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:14 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	2 Direct Exp (Sch IX, Col.13)	3 Allocated Expense	4 Total Exp for Stepdown	5 Bldg and Fixed Deprec	6 Fringe Benefits	7 Adminis-tration
38	Respiratory Therapy						
39	Pulmonary Function Test						
40	Electroencephalography	724					
41	Electromyography						
42	Physical Therapy	172					
43	Occupational Therapy	163,313			1,868	40,958	48,569
44	Speech-Language Therapy						
45	Recreational Therapy						
46	Audiology						
47	Psychology / Psychiatry	123,457				31,448	37,292
48	Renal Dialysis						
49	Organ Acquisition						
50	Ambulance	448					
51	PROF BILLING INPATIENT						
52	PROF BILLING OUTPATIENT						
53	VOCATIONAL EDUCATION	4,045			2,802		
54	Professional Services						
55	Other Ancillary (Specify)						
56	Subtotal Ancillary	309,907			4,670	72,406	85,861
	Routine Inpatient Care Services						
57	Medical & Surgical Acute						
58	Pediatric Acute						
59	Obstetric Acute						
60	Psychiatric Acute	1,643,652			17,497	384,710	486,438
61	Ventilator Unit						
62	Skilled Nursing Facilities						
63	Other Acute (Specify)						
64	Other Acute (Specify)						
65	Other Acute (Specify)						
66	Subtotal Acute	1,643,652			17,497	384,710	486,438
	Med-Surg Intensive Care						
67	Med/Surg Intensive Care						
68	Coronary Intensive Care						
69	Neonatal Intensive Care						
70	Other ICU (Specify)						
71	Other ICU (Specify)						
72	Other ICU (Specify)						
73	Other ICU (Specify)						
74	Other ICU (Specify)						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	2 Direct Exp (Sch IX, Col.13)	3 Allocated Expense	4 Total Exp for Stepdown	5 Bldg and Fixed Deprec	6 Fringe Benefits	7 Adminis-tration
75	Subtotal Intensive Care						
76	Newborn Nursery						
76.01	Special Care Nursery						
77	Chronic / Rehabilitation						
78	Subtotal Routine Inpat Care	1,643,652			17,497	384,710	486,438
	Routine Ambulatory Care Services						
79	Emergency Services	1,370			2,846	18,550	23,205
80	Clinic / Ambulatory Services	243,500			3,509	62,091	73,658
80.01	Clinic / Ambulatory Svcs (Specify)	243,500			3,509	62,091	73,658
81	Satellite Clinic Services						
82	Ambulatory Surgical Services						
83	Ambulatory Renal Dialysis						
84	Home Dialysis Services						
85	Psychiatry						
86	Home Health Services						
87	Observation Beds						
88	Private Referrals						
89	Hospital Licensed Health Centers						
90	Partial Hospitalization	171,552			4,366	35,880	42,547
91	Other Ambulatory (Specify)						
92	Subtotal Routine Ambul Svcs	416,422			10,721	116,521	139,410
93	Total Patient Care	2,369,981			32,888	573,637	711,709
94	Total Pat Care & Overhead	12,061,116			88,635	1,632,313	1,891,980
	Non-Patient care Services						
95	Non-Patient Ancillary						
96	Research	105,993			2,089		
97	COMMUNITY MH SERVICES	146					
97.01	CASE MANAGEMENT SERVICES	-25,271			2,926		
97.02	REHAB OPTION SERVICES	1,526					
97.03	NON PATIENT EXPENSES	488			1,831		
97.04	COMMUNITY REHAB.SUPPORT	436					
97.05	SEE						
97.06	Youth Mobile Crisis Int						
98	Subtotal Non-Patient	83,318			6,846		
99	Recovery of Expenses						
100	Total Patient/Non-Patient	12,144,434			95,481	1,632,313	1,891,980
101	Provision for Bad Debts						
101.01	Gross Health Safety Net Assessment	1					
102	Total Patient/Non-Patient/Bad Debt/HSN	12,144,435			95,481	1,632,313	1,891,980

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	8 Plant Maint.& Repairs	9 Plant Operations	10 Laundry + Linen	11 House-keeping	12 Cafeteria	13 Dietary
	Overhead						
1	Buildings / Fixed Depreciation						
2	Fringe Benefits						
3	Administration						
4	Plant Maintenance / Repairs						
5	Plant Operations	64,408					
6	Laundry and Linen	900	3,058				
7	Housekeeping	5,685	19,322				
8	Cafeteria						
9	Dietary Services	44,796	152,250		71,716		
10	Maintenance of Personnel						
11	Nursing Administration	6,181	21,008		9,896		
12	RN / LPN Education						
13	Medical Staff - Teaching	4,443	15,100		7,113		
14	Post Graduate Medical Education						
15	Central Services & Supplies						
16	Pharmacy						
17	Medical Records	11,294	38,384		18,080		
18	Medical Care Review						
19	Social Services	16,810	57,133		26,912		
20	Other Overhead (Specify)						
21	Subtotal Overhead	154,517	306,255		133,717		
	Ancillary Care Services						
22	Surgery						
23	Labor & Delivery						
24	Recovery Room						
25	Anesthesiology						
26	Intravenous Therapy						
27	Medical Supplies - Special						
28	Drugs - Special						
29	Laboratory						
30	Blood						
31	Blood Processing / Storage						
32	Electrocardiology (EKG)						
33	Cardiac Cath Laboratory						
34	Diagnostic Radiology						
35	Therapeutic Radiology						
36	Computerized Tomography						
37	Nuclear Medicine						

COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	8 Plant Maint.& Repairs	9 Plant Operations	10 Laundry + Linen	11 House-keeping	12 Cafeteria	13 Dietary
38	Respiratory Therapy						
39	Pulmonary Function Test						
40	Electroencephalography						
41	Electromyography						
42	Physical Therapy						
43	Occupational Therapy	6,948	23,614		11,123		
44	Speech-Language Therapy						
45	Recreational Therapy						
46	Audiology						
47	Psychology / Psychiatry						
48	Renal Dialysis						
49	Organ Acquisition						
50	Ambulance						
51	PROF BILLING INPATIENT						
52	PROF BILLING OUTPATIENT						
53	VOCATIONAL EDUCATION	10,424	35,430		16,689		
54	Professional Services						
55	Other Ancillary (Specify)						
56	Subtotal Ancillary	17,372	59,044		27,812		
	Routine Inpatient Care Services						
57	Medical & Surgical Acute						
58	Pediatric Acute						
59	Obstetric Acute						
60	Psychiatric Acute	65,098	221,252	11,688	104,218		490,105
61	Ventilator Unit						
62	Skilled Nursing Facilities						
63	Other Acute (Specify)						
64	Other Acute (Specify)						
65	Other Acute (Specify)						
66	Subtotal Acute	65,098	221,252	11,688	104,218		490,105
	Med-Surg Intensive Care						
67	Med/Surg Intensive Care						
68	Coronary Intensive Care						
69	Neonatal Intensive Care						
70	Other ICU (Specify)						
71	Other ICU (Specify)						
72	Other ICU (Specify)						
73	Other ICU (Specify)						
74	Other ICU (Specify)						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	8 Plant Maint.& Repairs	9 Plant Operations	10 Laundry + Linen	11 House-keeping	12 Cafeteria	13 Dietary
75	Subtotal Intensive Care						
76	Newborn Nursery						
76.01	Special Care Nursery						
77	Chronic / Rehabilitation						
78	Subtotal Routine Inpat Care	65,098	221,252	11,688	104,218		490,105
	Routine Ambulatory Care Services						
79	Emergency Services	10,588	35,986		16,951		
80	Clinic / Ambulatory Services	13,052	44,361		20,896		
80.01	Clinic / Ambulatory Svcs (Specify)	13,052	44,361		20,896		
81	Satellite Clinic Services						
82	Ambulatory Surgical Services						
83	Ambulatory Renal Dialysis						
84	Home Dialysis Services						
85	Psychiatry						
86	Home Health Services						
87	Observation Beds						
88	Private Referrals						
89	Hospital Licensed Health Centers						
90	Partial Hospitalization	16,243	55,204		26,003		
91	Other Ambulatory (Specify)						
92	Subtotal Routine Ambul Svcs	39,883	135,551		63,850		
93	Total Patient Care	122,353	415,847	11,688	195,880		490,105
94	Total Pat Care & Overhead	276,870	722,102	11,688	329,597		490,105
	Non-Patient care Services						
95	Non-Patient Ancillary						
96	Research	7,771	26,412		12,441		
97	COMMUNITY MH SERVICES						
97.01	CASE MANAGEMENT SERVICES	10,885	36,994		17,426		
97.02	REHAB OPTION SERVICES						
97.03	NON PATIENT EXPENSES	6,810	23,145	2,922	10,902		487,426
97.04	COMMUNITY REHAB.SUPPORT						
97.05	SEE						
97.06	Youth Mobile Crisis Int						
98	Subtotal Non-Patient	25,466	86,551	2,922	40,769		487,426
99	Recovery of Expenses						
100	Total Patient/Non-Patient	302,336	808,653	14,610	370,366		977,531
101	Provision for Bad Debts						
101.01	Gross Health Safety Net Assessment						
102	Total Patient/Non-Patient/Bad Debt/HSN	302,336	808,653	14,610	370,366		977,531

COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	14 Main-tenance of Personnel	15 Nursing Adminis-tration	16 RN and LPN Education	17 Medical Staff - Teaching	18 Post Grad Medical Education	19 Central Service & Supplies
	Overhead						
1	Buildings / Fixed Depreciation						
2	Fringe Benefits						
3	Administration						
4	Plant Maintenance / Repairs						
5	Plant Operations						
6	Laundry and Linen						
7	Housekeeping						
8	Cafeteria						
9	Dietary Services						
10	Maintenance of Personnel						
11	Nursing Administration						
12	RN / LPN Education						
13	Medical Staff - Teaching						
14	Post Graduate Medical Education						
15	Central Services & Supplies						
16	Pharmacy						
17	Medical Records						
18	Medical Care Review						
19	Social Services						
20	Other Overhead (Specify)						
21	Subtotal Overhead						
	Ancillary Care Services						
22	Surgery						
23	Labor & Delivery						
24	Recovery Room						
25	Anesthesiology						
26	Intravenous Therapy						
27	Medical Supplies - Special						
28	Drugs - Special						
29	Laboratory						
30	Blood						
31	Blood Processing / Storage						
32	Electrocardiology (EKG)						
33	Cardiac Cath Laboratory						
34	Diagnostic Radiology						
35	Therapeutic Radiology						
36	Computerized Tomography						
37	Nuclear Medicine						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	14 Main-tenance of Personnel	15 Nursing Adminis-tration	16 RN and LPN Education	17 Medical Staff - Teaching	18 Post Grad Medical Education	19 Central Service & Supplies
38	Respiratory Therapy						
39	Pulmonary Function Test						
40	Electroencephalography						
41	Electromyography						
42	Physical Therapy						
43	Occupational Therapy						
44	Speech-Language Therapy						
45	Recreational Therapy						
46	Audiology						
47	Psychology / Psychiatry						
48	Renal Dialysis						
49	Organ Acquisition						
50	Ambulance						
51	PROF BILLING INPATIENT						
52	PROF BILLING OUTPATIENT						
53	VOCATIONAL EDUCATION						
54	Professional Services						
55	Other Ancillary (Specify)						
56	Subtotal Ancillary						
	Routine Inpatient Care Services						
57	Medical & Surgical Acute						
58	Pediatric Acute						
59	Obstetric Acute						
60	Psychiatric Acute		768,848		720,670		
61	Ventilator Unit						
62	Skilled Nursing Facilities						
63	Other Acute (Specify)						
64	Other Acute (Specify)						
65	Other Acute (Specify)						
66	Subtotal Acute		768,848		720,670		
	Med-Surg Intensive Care						
67	Med/Surg Intensive Care						
68	Coronary Intensive Care						
69	Neonatal Intensive Care						
70	Other ICU (Specify)						
71	Other ICU (Specify)						
72	Other ICU (Specify)						
73	Other ICU (Specify)						
74	Other ICU (Specify)						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	14 Main-tenance of Personnel	15 Nursing Adminis-tration	16 RN and LPN Education	17 Medical Staff - Teaching	18 Post Grad Medical Education	19 Central Service & Supplies
75	Subtotal Intensive Care						
76	Newborn Nursery						
76.01	Special Care Nursery						
77	Chronic / Rehabilitation						
78	Subtotal Routine Inpat Care		768,848		720,670		
	Routine Ambulatory Care Services						
79	Emergency Services				377,494		
80	Clinic / Ambulatory Services		8,267		428,971		
80.01	Clinic / Ambulatory Svcs (Specify)		8,267		428,971		
81	Satellite Clinic Services						
82	Ambulatory Surgical Services						
83	Ambulatory Renal Dialysis						
84	Home Dialysis Services						
85	Psychiatry						
86	Home Health Services						
87	Observation Beds						
88	Private Referrals						
89	Hospital Licensed Health Centers						
90	Partial Hospitalization		49,603		188,747		
91	Other Ambulatory (Specify)						
92	Subtotal Routine Ambul Svcs		57,870		995,212		
93	Total Patient Care		826,718		1,715,882		
94	Total Pat Care & Overhead		826,718		1,715,882		
	Non-Patient care Services						
95	Non-Patient Ancillary						
96	Research						
97	COMMUNITY MH SERVICES						
97.01	CASE MANAGEMENT SERVICES						
97.02	REHAB OPTION SERVICES						
97.03	NON PATIENT EXPENSES						
97.04	COMMUNITY REHAB.SUPPORT						
97.05	SEE						
97.06	Youth Mobile Crisis Int						
98	Subtotal Non-Patient						
99	Recovery of Expenses						
100	Total Patient/Non-Patient		826,718		1,715,882		
101	Provision for Bad Debts						
101.01	Gross Health Safety Net Assessment						
102	Total Patient/Non-Patient/Bad Debt/HSN		826,718		1,715,882		

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	20 Pharmacy	21 Medical Records	22 Medical Care Review	23 Social Services	24 Other Overhead	25 Total Exp After Stepdown
	Overhead						
1	Buildings / Fixed Depreciation						
2	Fringe Benefits						
3	Administration						
4	Plant Maintenance / Repairs						
5	Plant Operations						
6	Laundry and Linen						
7	Housekeeping						
8	Cafeteria						
9	Dietary Services						
10	Maintenance of Personnel						
11	Nursing Administration						
12	RN / LPN Education						
13	Medical Staff - Teaching						
14	Post Graduate Medical Education						
15	Central Services & Supplies						
16	Pharmacy						
17	Medical Records						
18	Medical Care Review						
19	Social Services						
20	Other Overhead (Specify)						
21	Subtotal Overhead						
	Ancillary Care Services						
22	Surgery						
23	Labor & Delivery						
24	Recovery Room						
25	Anesthesiology						176
26	Intravenous Therapy						
27	Medical Supplies - Special						78
28	Drugs - Special	145,523					145,523
29	Laboratory						17,243
30	Blood						
31	Blood Processing / Storage						
32	Electrocardiology (EKG)						108
33	Cardiac Cath Laboratory						
34	Diagnostic Radiology						143
35	Therapeutic Radiology						
36	Computerized Tomography						
37	Nuclear Medicine						

COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	20 Pharmacy	21 Medical Records	22 Medical Care Review	23 Social Services	24 Other Overhead	25 Total Exp After Stepdown
38	Respiratory Therapy						
39	Pulmonary Function Test						
40	Electroencephalography						724
41	Electromyography						
42	Physical Therapy						172
43	Occupational Therapy						296,393
44	Speech-Language Therapy						
45	Recreational Therapy						
46	Audiology						
47	Psychology / Psychiatry						192,197
48	Renal Dialysis						
49	Organ Acquisition						
50	Ambulance						448
51	PROF BILLING INPATIENT						
52	PROF BILLING OUTPATIENT						
53	VOCATIONAL EDUCATION						69,390
54	Professional Services						
55	Other Ancillary (Specify)						
56	Subtotal Ancillary	145,523					722,595
	Routine Inpatient Care Services						
57	Medical & Surgical Acute						
58	Pediatric Acute						
59	Obstetric Acute						
60	Psychiatric Acute		133,845	22,787	480,612		5,551,420
61	Ventilator Unit						
62	Skilled Nursing Facilities						
63	Other Acute (Specify)						
64	Other Acute (Specify)						
65	Other Acute (Specify)						
66	Subtotal Acute		133,845	22,787	480,612		5,551,420
	Med-Surg Intensive Care						
67	Med/Surg Intensive Care						
68	Coronary Intensive Care						
69	Neonatal Intensive Care						
70	Other ICU (Specify)						
71	Other ICU (Specify)						
72	Other ICU (Specify)						
73	Other ICU (Specify)						
74	Other ICU (Specify)						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2330 Provider Name: CORRIGAN MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:58:15 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	20 Pharmacy	21 Medical Records	22 Medical Care Review	23 Social Services	24 Other Overhead	25 Total Exp After Stepdown
75	Subtotal Intensive Care						
76	Newborn Nursery						
76.01	Special Care Nursery						
77	Chronic / Rehabilitation						
78	Subtotal Routine Inpat Care		133,845	22,787	480,612		5,551,420
	Routine Ambulatory Care Services						
79	Emergency Services		133,846		2,300,072		2,920,908
80	Clinic / Ambulatory Services		48,047		205,977		1,152,329
80.01	Clinic / Ambulatory Svcs (Specify)		48,047		205,977		1,152,329
81	Satellite Clinic Services						
82	Ambulatory Surgical Services						
83	Ambulatory Renal Dialysis						
84	Home Dialysis Services						
85	Psychiatry						
86	Home Health Services						
87	Observation Beds						
88	Private Referrals						
89	Hospital Licensed Health Centers						
90	Partial Hospitalization		13,728		446,283		1,050,156
91	Other Ambulatory (Specify)						
92	Subtotal Routine Ambul Svcs		195,621		2,952,332		5,123,393
93	Total Patient Care	145,523	329,466	22,787	3,432,944		11,397,408
94	Total Pat Care & Overhead	145,523	329,466	22,787	3,432,944		11,397,408
	Non-Patient care Services						
95	Non-Patient Ancillary						
96	Research						154,706
97	COMMUNITY MH SERVICES		6,864				7,010
97.01	CASE MANAGEMENT SERVICES		6,864				49,824
97.02	REHAB OPTION SERVICES						1,526
97.03	NON PATIENT EXPENSES						533,524
97.04	COMMUNITY REHAB.SUPPORT						436
97.05	SEE						
97.06	Youth Mobile Crisis Int						
98	Subtotal Non-Patient		13,728				747,026
99	Recovery of Expenses						
100	Total Patient/Non-Patient	145,523	343,194	22,787	3,432,944		12,144,434
101	Provision for Bad Debts						
101.01	Gross Health Safety Net Assessment						1
102	Total Patient/Non-Patient/Bad Debt/HSN	145,523	343,194	22,787	3,432,944		12,144,435

Cape Cod and the Islands Emergency Services Program (ESP) Cost Forms

APPENDIX C (Form 2)

In-House Cost Estimate

FULLY ALLOCATED COST

	Fiscal Year 2016	Avoidable Cost	Fiscal Year 2017	Avoidable Cost	Fiscal Year 2018	Avoidable Cost	Total	Avoidable Cost
Direct Costs								
Personnel Cost	$ 2,105,202.84	$ 2,105,202.84	$ 2,169,824.29	$ 2,169,824.29	$ 2,235,810.97	$ 2,235,810.97	$ 6,510,838.10	$ 6,510,838.10
Material and Supply Costs	$ 931.70	$ 931.70	$ 960.30	$ 960.30	$ 989.51	$ 989.51	$ 2,881.52	$ 2,881.52
Other Direct Costs								
Rent	$ -	$ -	$ 186,573.00	$ 186,573.00	$ 154,838.00	$ 154,838.00	$ 341,411.00	$ 341,411.00
Depreciation	$ 7,475.03	$ 7,475.03	$ 7,704.48	$ 7,704.48	$ 7,938.78	$ 7,938.78	$ 23,118.30	$ 23,118.30
Maintenance	$ 15,780.53	$ 15,780.53	$ 16,264.93	$ 16,264.93	$ 16,759.56	$ 16,759.56	$ 48,805.01	$ 48,805.01
Utilities	$ 33,001.80	$ 33,001.80	$ 34,014.83	$ 34,014.83	$ 35,049.25	$ 35,049.25	$ 102,065.88	$ 102,065.88
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ 1,932,513.87	$ 1,932,513.87	$ 1,991,834.44	$ 1,991,834.44	$ 2,052,408.26	$ 2,052,408.26	$ 5,976,756.57	$ 5,976,756.57
Indirect Costs								
Departmental	$ 172,879.75	$ -	$ 178,186.48	$ -	$ 183,605.32	$ -	$ 534,671.54	$ -
Executive Office	$ 53,785.25	$ -	$ 55,436.25	$ -	$ 57,122.13	$ -	$ 166,343.63	$ -
Central Services	$ 17,514.36	$ -	$ 18,051.98	$ -	$ 18,600.96	$ -	$ 54,167.31	$ -
Total In-House Costs	**$ 4,339,085.13**	**$ 4,094,905.77**	**$ 4,658,850.98**	**$ 4,407,176.27**	**$ 4,763,122.75**	**$ 4,503,794.34**	**$ 13,761,058.87**	**$ 13,005,876.38**
Less Total Revenue	$ 381,367.89	$ 381,367.89	$ 393,074.39	$ 393,074.39	$ 405,028.20	$ 405,028.20	$ 1,179,470.48	$ 1,179,470.48
Total Costs	$ 3,957,717.24	$ 3,713,537.88	$ 4,265,776.59	$ 4,014,101.88	$ 4,358,094.55	$ 4,098,766.14	$ 12,581,588.38	$ 11,826,405.90

APPENDIX C (Form 2a)

Summary In-House Cost Estimate

	Current Operating Budget	Adjustments	Revised Total Cost Period A	Adjustments	Revised Total Cost Period B	Adjustments	Revised Total Cost Period C
Direct Cost							
		2.91%		3.07%		3.04%	
Personnel Wages							
Clerk III	$ 49,176.67	$ 1,433.18	$ 50,609.85	$ 1,553.52	$ 52,163.37	$ 1,586.34	$ 53,749.72
Clinical Social Worker (A/B)	$ 272,175.32	$ 7,932.14	$ 280,107.46	$ 8,598.20	$ 288,705.65	$ 8,779.85	$ 297,485.50
Clinical Social Worker (C)	$ 104,754.23	$ 3,052.90	$ 107,807.13	$ 3,309.25	$ 111,116.39	$ 3,379.17	$ 114,495.55
Clinical Social Worker (D)	$ 234,206.45	$ 6,825.59	$ 241,032.04	$ 7,398.74	$ 248,430.78	$ 7,555.05	$ 255,985.83
Human Services Coordinator (C)	$ 982,337.88	$ 28,628.76	$ 1,010,966.63	$ 31,032.70	$1,041,999.33	$ 31,688.32	$1,073,687.65
Human Services Coordinator (D)	$ 85,617.98	$ 2,495.21	$ 88,113.18	$ 2,704.73	$ 90,817.91	$ 2,761.87	$ 93,579.78
Mental Health Coordinator I	$ 259,834.72	$ 7,572.49	$ 267,407.21	$ 8,208.35	$ 275,615.56	$ 8,381.77	$ 283,997.33
Social Worker (C)	$ 57,484.04	$ 1,675.29	$ 59,159.33	$ 1,815.96	$ 60,975.29	$ 1,854.32	$ 62,829.61
Materials & Supplies							
Office Supplies	$ 99.75	$ 2.91	$ 102.66	$ 3.15	$ 105.81	$ 3.22	$ 109.03
Equipment Purchase	$ 805.57	$ 23.48	$ 829.05	$ 25.45	$ 854.50	$ 25.99	$ 880.48
Other Direct Costs							
Travel and Other Employee Reimb.	$ 65,868.73	$ 1,919.64	$ 67,788.37	$ 2,080.84	$ 69,869.21	$ 2,124.80	$ 71,994.01
Payroll Taxes	$ 26,193.84	$ 763.38	$ 26,957.22	$ 827.48	$ 27,784.71	$ 844.96	$ 28,629.67
Office Equipment Lease	$ 1,485.88	$ 43.30	$ 1,529.18	$ 46.94	$ 1,576.12	$ 47.93	$ 1,624.06
Depreciation	$ 7,263.35	$ 211.68	$ 7,475.03	$ 229.45	$ 7,704.48	$ 234.30	$ 7,938.78
Administration	$ 190,664.56	$ 5,556.63	$ 196,221.19	$ 6,023.22	$ 202,244.41	$ 6,150.47	$ 208,394.88
Plant Maintenance	$ 15,333.65	$ 446.88	$ 15,780.53	$ 484.40	$ 16,264.93	$ 494.63	$ 16,759.56
Plant Operations	$ 32,067.25	$ 934.55	$ 33,001.80	$ 1,013.03	$ 34,014.83	$ 1,034.43	$ 35,049.25
Housekeeping	$ 13,696.90	$ 399.18	$ 14,096.08	$ 432.69	$ 14,528.77	$ 441.84	$ 14,970.61
Contracted Observation Beds	$ 890,741.64	$ 25,959.32	$ 916,700.96	$ 28,139.11	$ 944,840.08	$ 28,733.60	$ 973,573.68
Medical Staff	$ 689,137.00	$ 20,083.86	$ 709,220.86	$ 21,770.29	$ 730,991.15	$ 22,230.23	$ 753,221.38
Total Direct Costs	$3,978,945.40	$115,960.37	$ 4,094,905.77	$125,697.50	$4,220,603.27	$128,353.08	$4,348,956.34
Indirect Costs							
Departmental	$ 167,984.10	$ 4,895.64	$ 172,879.75	$ 5,306.73	$ 178,186.48	$ 5,418.84	$ 183,605.32
Executive Office	$ 52,262.15	$ 1,523.10	$ 53,785.25	$ 1,651.00	$ 55,436.25	$ 1,685.88	$ 57,122.13
Central Services	$ 17,018.39	$ 495.98	$ 17,514.36	$ 537.62	$ 18,051.98	$ 548.98	$ 18,600.96
Total Indirect Costs	$ 237,264.64	$ 6,914.72	$ 244,179.36	$ 7,495.35	$ 251,674.71	$ 7,653.70	$ 259,328.41
Total Direct & Indirect Costs	$4,216,210.05	$122,875.09	$ 4,339,085.13	$133,192.84	$4,472,277.98	$136,006.78	$4,608,284.75
Less Total Revenue	$ 370,568.24	$ 10,799.65	$ 381,367.89	$ 11,706.49	$ 393,074.39	$ 11,953.81	$ 405,028.20
Total Costs	$3,845,641.81	$112,075.43	$ 3,957,717.24	$121,486.35	$4,079,203.59	$124,052.96	$4,203,256.55

APPENDIX C (Form 2b)

Personnel Cost Worksheet

Position Title or Skill	FTEs Required	Annual Wage	Other Pay	Basic Pay	Fringe Benefits	Personnel Cost
Clerk III	1.00	$ 38,639.64	$ -	$ 38,639.64	$ 10,537.03	$ 49,176.67
Clinical Social Worker (A/B)	3.00	$ 214,630.07	$ 1,686.94	$ 216,317.01	$ 55,858.31	$ 272,175.32
Clinical Social Worker (C)	1.00	$ 82,530.60	$ 387.60	$ 82,918.20	$ 21,836.03	$ 104,754.23
Clinical Social Worker (D)	2.00	$ 193,091.57	$ 91.71	$ 193,183.28	$ 41,023.17	$ 234,206.45
Human Services Coordinator (C)	9.60	$ 773,660.25	$ 20,308.80	$ 793,969.05	$ 188,368.83	$ 982,337.88
Human Services Coordinator (D)	1.00	$ 67,526.60	$ 1,919.34	$ 69,445.94	$ 16,172.04	$ 85,617.98
Mental Health Coordinator I	4.10	$ 201,834.67	$ 5,662.02	$ 207,496.69	$ 52,338.03	$ 259,834.72
Social Worker (C)	0.60	$ 43,641.40	$ 1,800.39	$ 45,441.79	$ 12,042.25	$ 57,484.04
	22.30	**$1,615,554.80**	**$31,856.79**	**$1,647,411.60**	**$398,175.69**	**$2,045,587.28**

Form 2A Notes

The Emergency Services Program servicing Cape Cod, Martha's Vineyard and Nantucket is primarily based at a facility located at 830 County Road Pocasset, MA 02559. The center services the communities of Aquinnah, Barnstable, Bourne, Brewster, Chatham, Chilmark, Cotuit, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Gosnold, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Osterville, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Woods Hole, and Yarmouth. The center offers a number of behavioral health services in addition to the ESP program's Community Based Location and a Crisis Stabilization Program.

All costs included in this form include only relevant sub-units related to the ESP program.[9]

Direct Costs

Personnel

The current operating budget, for the purpose of this report, is assumed as FY15 and as such is derived from the same sources as those outlined in the details related to Form 2b, which is also included in these financial notes. The *Adjustment* column is based on an average of quarterly CMS Market Basket Index Levels between FY15 and FY16. When applied to the current operating budget, this federally derived adjustment produces the form's "Revised Total Cost Period A". Subsequent years are calculated in a similar fashion.

Materials and Supplies

The object class included in this analysis associated with office supplies is defined as EE (administrative expense) and object E01 (office and admin supplies). Object codes related to indirect cost recoupment and recreation, religious and social supplies and materials were excluded. Equipment Purchase includes all object codes within the object class associated with "Equipment purchasing, technology equipment lease purchase (TELP), lease, rental, maintenance, and repair" including KK (programmatic equipment purchase), LL (programmatic equipment tax exempt lease-purchase - TELP), lease and rental, maintenance, and repair), N62 (TELP lease purchase of facility infrastructure maintenance and lawn and grounds), N63 (rental or lease of facility infrastructure maintenance and lawn and grounds equipment), U08 (information technology equipment TELP lease-purchase), and U09 (information technology equipment rental or lease). Object codes under LL (programmatic equipment tax exempt lease-purchase - TELP) all referred to equipment leases and were excluded as they are contemplated directly in other direct cost analysis, *Office Equipment Lease*. A full list of expenses can be found in exhibit 17, Cape ESP FY14 Expenses on page 607.

Other Direct Costs

Travel and Other Employee Reimbursements

Costs include those associated with the following object codes: B02 (In-State Travel), B03 (Overtime Meals), and B91 (Employee Reimbursement Accounts Payable Non-tax). Object class AA (state employee compensation) and object D09 (fringe benefit costs recoupment) were excluded as they are contemplated in Form 2b. A full list of expenses can be found in exhibit 17, Cape ESP FY14 Expenses on page 607.

[9] These sub-units as typically reported through the program's expense ledger and are classified collectively as *Crisis Services;* their sub-unit codes are 00AK and 00YA.

Payroll Taxes

Payroll taxes collected by the Commonwealth were not netted from the totals of Form 2A Summary of In-House Cost Estimates. This dollar amount (1.59% for FY15 or $160,099 for FY16 after adjustments) represents taxes paid by DMH to the Commonwealth. As the total FTE and salary levels attributed directly to the SE ESP operations of the vendor are not known, it was not possible to identify a corresponding increase or decrease in payroll taxes paid to the Commonwealth by either vendor as a result of the privatization. Therefore a conservative approach was taken to assume that these dollar amounts would be relatively similar and that the overall impact to the Commonwealth would not be material.

Office Equipment Lease

Expenditures associated with office equipment lease include the object code L26 (Printing/Photocopy and micrographics equipment/lease). A full list of expenses can be found in exhibit 17, Cape ESP FY14 Expenses on page 607.

Depreciation

Depreciation costs were determined using data from the Cape Cod and the Islands Mental Health Center FY14 Hospital 403 Cost Report as submitted to Massachusetts CHIA provided in exhibit 20 on page 613. Depreciation costs include those amounts related to social services that are allocated to ESP.[10]

Administration

Administration costs were determined using data from the Cape and the Islands Mental Health Center FY14 Hospital 403 Cost Report as submitted to CHIA on page 613. Total administration costs were allocated to thefacility based on the proportion of facility cost to total cost. The final cost includes those amounts pertaining to social services that are allocated to clinic/ambulatory services.

Plant Maintenance, Plant Ops, and Housekeeping

Costs were determined using data from the Cape and the Islands Mental Health Center FY14, 403 report on page 613 and include those amounts pertaining to social services that are allocated to the emergency services program.

Contracted Observation Beds

The total contracted observation beds represents the total cost of the subcontract with Vinfen Corporation to provide these services. This contract is provided in exhibit 21 on page 625.

Medical Staff

Costs associated with Medical Staff were based on the Cape Cod and the Islands Mental Health Center FY14 403 cost report on page 613 (Schedule XV, Column 17, line 80).

Indirect Costs

All indirect costs including Departmental, Executive Office, and Central Services were calculated using the FY14 Department of Mental Health Cost Allocation Plan dated 11/26/2014.

[10] Schedule XIII, Column 23

Form 2B Notes

FY15 salary data is derived from CY14 salary data (MRS CY14) amounts. “Annual Wage” includes all costs associated with personnel codes A01 (salaries), A06 (stand-by pay), A08 (overtime pay) and AA1 (supplemental salaries) for all applicable program personnel. “Other Pay” includes costs associated with personnel codes A07 (shift differential pay) for all applicable program personnel. “Basic Pay” is the sum of the annual wage and other pay. “Fringe Benefits” includes costs associated with personnel codes A01, A07 and AA1 from the CY14 payroll data multiplied by the FY15 Fringe Benefit Rate of 27.27%. “Personnel Costs” includes all applicable basic pay and fringe pay. All personnel cost information can be found in exhibit 19 on page 612.

Form 2A/2B Data Sources

Exhibit	Source	Used in Form	Description
16	FY15 Revenue by Payer	2/2A	Total revenue collected by payer for the facility in FY15
17	Cape & Islands FY14 Expenses	2A	List of Cape & Island expenses for the Crisis sub units, filtered for relevant costs included in form 2A
18	Allocated Cost Calculation	2A	Total overhead costs and amounts to be allocated to crisis
19	Cape ESP Payroll Projection	2B	Total FTE counts and estimated salary costs by position for Cape & Islands
20	Cape Cod & the Islands Mental Health Center Medicaid 403 Cost Report	2A	Medicaid Cost Report as filed with CHIA for Fiscal Year 2014
21	Vinfen Contract for CCS	2A	Contract detailing costs for Contracted Observation Beds
22	Hyannis Contract (for Lease)	2	Contract detailing anticipated rent costs for move to Hyannis facility

Exhibit 16: FY15 Revenue by Payer

Revenue by Dept. by Payer
Pocasset FY15

NOTE: Medicaid FFP amounts reflect the actual revenue received

Dept	July Billed	Received	August Billed	Received	Sept Billed	Received	Oct Billed	Received	Nov Billed	Received	Dec Billed	Received
BRK Crisis												
B/C	1,146.00	-	777.00	-	2,627.60	1,514.17	5,037.00	1,423.14	(1,722.00)	-	(2,415.00)	-
Medicaid	33,711.31	27,603.22	17,794.27	27,129.62	22,201.74	23,287.11	28,634.95	16,805.75	20,944.36	22,856.87	37,048.24	30,065.78
Medicaid FFP		13,801.61		13,564.81		11,643.56		8,402.88		11,428.44		15,032.89
Medicare	18,717.00	1,403.54	12,534.00	3,038.68	13,059.00	3,163.74	8,598.00	1,789.54	10,893.58	1,528.60	8,604.00	1,984.10
Comm	33,024.00	5,698.96	18,813.00	8,275.12	28,389.00	3,660.40	12,624.00	9,027.18	29,826.00	3,764.64	31,548.00	3,496.32
Self/Free	68,332.78	-	49,439.14	-	66,469.56	-	53,031.26	-	53,791.39	-	72,332.23	-
Total	154,931.09	34,705.72	99,357.41	38,443.42	132,746.90	31,625.42	107,925.21	29,045.61	113,733.33	28,150.11	147,117.47	35,546.20
% Received		22%		39%		24%		27%		25%		24%

Dept	Jan Billed	Received	Feb Billed	Received	March Billed	Received	April Billed	Received	May Billed	Received	June Billed	Received
BRK Crisis												
B/C	777.00	1,072.02	900.00	-	1,968.00	720.00	2,376.00	349.73	3,354.00	685.73	(654.00)	1,647.79
Medicaid	23,624.01	26,217.41	27,271.01	12,628.17	21,372.59	29,633.98	32,317.20	23,573.09	21,002.78	23,311.00	23,241.43	9,457.52
Medicaid FFP		13,108.71		6,314.09		14,816.99		11,786.55		11,655.50		4,728.76
Medicare	7,772.42	1,267.66	5,976.00	1,392.72	8,055.00	1,570.98	11,130.00	1,744.95	5,763.00	2,895.91	3,602.00	1,986.76
Comm	21,150.00	4,568.24	19,752.00	7,164.82	20,486.00	4,328.16	23,887.00	3,005.95	30,480.00	5,724.32	27,563.00	8,104.85
Self/Free	54,712.39	-	60,490.09	-	44,429.90	-	46,361.18	-	53,316.24	-	42,660.76	-
Total	108,035.82	33,125.33	114,389.10	21,185.71	96,311.49	36,253.12	116,071.38	28,673.72	113,916.02	32,616.96	96,413.19	21,196.92
% Received		31%		19%		38%		25%		29%		22%

	Total YTD Billed	Total YTD Received
BRK Crisis		
B/C	14,171.60	7,412.58
Medicaid	309,163.89	272,569.52
Medicaid FFP		136,284.76
Medicare	114,704.00	23,767.18
Comm	297,542.00	66,818.96
Self/Free	665,366.92	-
Total	1,400,948.41	370,568.24
% Received		26%

Run Period end: Accounts receivable: INS GRP/INS/ACCT TYPE REPORT

Exhibit 17: Cape Cod & Islands Community Mental Health Center Expenses
Fiscal Year 2014

budget fiscal year	fiscal year	fiscal period	department	department name	division	division name	district	district name	unit	unit name	sub unit	sub unit name	cash expense amount	appropriation	appropriation name	appropriation type	appropriation type name	fund	object	object name	object class	object class name	activity	activity name	legal name	acceptance date
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	2385.45	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Dec-13
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	1841.4	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		25-Feb-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	252	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		17-Dec-13
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	718.6	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		22-Apr-14
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	1685.1	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		22-Apr-14
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	940.95	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		25-Mar-14
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	187.84	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	03-Mar-14
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	586.8	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		21-Nov-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	720	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		17-Jun-14
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	99.75	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	E01	Office & Administrative Supplies	EE	ADMINISTRATIVE EXPENSES	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	NEW ENGLAND OFFICE SUPPLY, INC.	10-Feb-14
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	149.17	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	RICOH AMERICAS CORPORATION	30-Sep-13
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	962.1	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		26-Sep-13
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	2435.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		24-Oct-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	2068.2	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Jun-14
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	235.8	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		20-May-14
2014	2014	1	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	149.17	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	RICOH AMERICAS CORPORATION	29-Jul-13
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	187.84	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	30-Jun-14

2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	404.05	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		24-Oct-13
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	333	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		28-Jan-14
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	2858.4	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		25-Feb-14
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	187.84	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	27-May-14
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	121.9	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		23-May-14
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	-50	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	RICOH AMERICAS CORPORATION	28-Jan-14
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	3612.4	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		28-Jan-14
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	2254.95	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		25-Mar-14
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	97.52	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	K02	Educational Equipment	KK	EQUIPMENT PURCHASE	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	W. B MASON CO INC	31-Jan-14
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	1993.95	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		29-Aug-13
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	243	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		21-Nov-13
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	2537.05	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		28-Jan-14
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	1319.4	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		29-Aug-13
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	708.05	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	K07	Office Furnishings	KK	EQUIPMENT PURCHASE	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	W. B MASON CO INC	28-Feb-14
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	274.05	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		25-Mar-14
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	19.35	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		26-Sep-13
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	1272	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		08-Apr-14
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	339.75	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		24-Oct-13

2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	2120.4	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		20-May-14
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	127.75	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		29-Aug-13
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	202.5	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		25-Mar-14
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	2462.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		01-Aug-14
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	310.5	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		25-Feb-14
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	415.25	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		26-Sep-13
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	149.17	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	RICOH AMERICAS CORPORATION	28-Oct-13
2014	2014	7	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	638.05	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		28-Jan-14
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	733.9	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		01-Aug-14
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	48.03	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B03	Overtime Meals	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		24-Oct-13
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	375.75	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		08-Apr-14
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	406.8	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		29-Aug-13
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	306.35	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		08-Apr-14
2014	2014	2	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	149.17	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3018	OFFICE ADMIN - CLINIC/SITE OFFICE	RICOH AMERICAS CORPORATION	27-Aug-13
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	257.4	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		05-Dec-13
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	187.84	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	28-Apr-14
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	2535.3	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		26-Sep-13
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	116.1	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		21-Nov-13

2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	154.35	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		05-Dec-13
2014	2014	9	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	187.84	55352689	CAPE COD AND ISLANDS MENTAL HEALTH AND	3TN	Trusts	0300	L26	Printing/Photocopy & Micrographics Equip Rent/Lease	LL	EQUIPMENT LEASE-MAINTAIN/ REPAR	3119	OFFICE ADMIN - FACILITIES	RICOH AMERICAS CORPORATION	31-Mar-14
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00YA	YOUTH MOBILE CRISIS INTERVENTION CAPE	1453.05	50470001	EMERGENCY PROGRAMS & ACUTE MH CARE	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		21-Nov-13
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	3725.05	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		24-Oct-13
2014	2014	4	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	19.35	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3119	OFFICE ADMIN - FACILITIES		24-Oct-13
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	4656.4	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		07-Aug-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	2024.1	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Dec-13
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	189	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		20-May-14
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	176	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		07-Nov-13
2014	2014	10	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	3307.05	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		22-Apr-14
2014	2014	3	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	176.75	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		26-Sep-13
2014	2014	8	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	236.25	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		25-Feb-14
2014	2014	6	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	85.5	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		17-Dec-13
2014	2014	5	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	2384.55	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		21-Nov-13
2014	2014	11	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	198	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		06-May-14
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	488.5	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		17-Jun-14
2014	2014	12	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	2635.65	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B02	In-State Travel	BB	REGULAR EMPLOYEE RELATED EXPEN	3149	SOCIAL WORK SERVICES		17-Jun-14
2014	2014	13	DMH	DEPARTMENT OF MENTAL HEALTH	5000	METRO SOUTHEAST AREA	5430	POCASSET CMHC	5430	POCASSET CMHC	00AK	HYANNIS CRISIS SERVICE	487.75	50950015	STATE PSYCHIATRIC HOSPITALS AND	1CS	Direct Appropriations /subsidiarized	0010	B91	Employee Reimbursement Accounts Payable - Non-Tax	BB	REGULAR EMPLOYEE RELATED EXPEN	3025	PROGRAM MANAGEMENT - FACILITY		07-Aug-14

Exhibit 18: Allocated Cost Calculation

Cape Cod Mental Health Center

Fiscal Year 2014

	Departmental	Executive	Central Services
Allocated to Social Service	212,336	66,061	21,512
Social Service portion allocated to Emergency	138,018	42,939	13,983
Directly Allocated to Emergency	29,966	9,323	3,036
Total	167,984	52,262	17,018

Administration Cost Allocation Breakdown

	Expense alloc.	% To Total
Total Admin	1,681,893	
Departmental Allocation	660,160	39.25%
Executive Allocation	205,385	12.21%
Central Service Cost	66,880	3.98%
Facility Admin	749,467	44.56%
Admin Cost Allocated to Social Work	540,969	

Sources: CHIA FY14 Cost Report, FY14 DMH Home Office Cost Allocation Plan

Exhibit 19: Emergency Services Payroll Projection

Cape Cod and Islands Mental Health Center

Fiscal Year 2016

Base Salary Information - Source MRS - Through Pay Period 12/13/2014

description	fte	annual_rt
Clerk III Total	**1.00**	**38,640**
Clinical Social Worker (A/B) Total	**3.00**	**203,147**
Clinical Social Worker (C) Total	**1.00**	**79,686**
Clinical Social Worker (D) Total	**2.00**	**150,342**
Human Services Coordinator (C) Total	**9.60**	**654,492**
Human Services Coordinator (D) Total	**1.00**	**55,776**
Mental Health Coordinator I Total	**4.10**	**185,398**
Social Worker (C) Total	**0.60**	**41,393**
Grand Total	**22.30**	**1,408,873**

Fiscal Year 2014 Payroll - Source dbo.Labor_History table - Sub_Units 00AK and 00YA

title_description	unit	A01	A06	A07	A08	AA1	Diff %	Other %	Fringe Eligible %
Clerk III	5430	37,183					0.00%	0.00%	100.00%
Clinical Social Worker (A/B)	5430	126,133		1,047	7,130		0.83%	5.65%	100.83%
Clinical Social Worker (C)	5430	93,545		455	3,340		0.49%	3.57%	100.49%
Clinical Social Worker (D)	5430	142,425	5,268	87	35,231		0.06%	28.44%	100.06%
Human Services Coordinator (C)	5430	650,856	263	20,196	102,378	15,866	3.10%	18.21%	105.54%
Human Services Coordinator (D)	5430	17,699	53	609	3,166	510	3.44%	21.07%	106.32%
Mental Health Coordinator I	5430	103,687		3,167	8,709	484	3.05%	8.87%	103.52%
Social Worker (C)	5430	40,155		1,747	1,244	938	4.35%	5.43%	106.68%

Total Estimated Salary Costs

					27.27%	1.59%
title_description	FTE	Base Pay *	Other Pay	Annual Wage	Fringe Benefits	Payroll Tax
Clerk III	1.00	38,640	-	38,640	10,537	614
Clinical Social Worker (A/B)	3.00	203,147	1,687	214,630	55,858	3,439
Clinical Social Worker (C)	1.00	79,686	388	82,531	21,836	1,318
Clinical Social Worker (D)	2.00	150,342	92	193,092	41,023	3,072
Human Services Coordinator (C)	9.60	654,492	20,309	773,660	188,369	12,624
Human Services Coordinator (D)	1.00	55,776	1,919	67,527	16,172	1,104
Mental Health Coordinator I	4.10	185,398	5,662	201,835	52,338	3,299
Social Worker (C)	0.60	41,393	1,800	43,641	12,042	723
	22.30	**1,408,873**	**31,857**	**1,615,555**	**398,176**	**26,194**

*Basic Pay is all payroll less differential pay. Overtime pay is estimated based on prior year's and is included.

Exhibit 20: Cape & Islands' FY14 Medicaid 403 Cost Report

COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	2 Direct Exp (Sch IX, Col.13)	3 Allocated Expense	4 Total Exp for Stepdown	5 Bldg and Fixed Deprec	6 Fringe Benefits	7 Adminis-tration
	Overhead						
1	Buildings / Fixed Depreciation	137,693		137,693			
2	Fringe Benefits	1,271,326		1,271,326			
3	Administration	1,591,036	90,857	1,681,893	17,810	73,047	
4	Plant Maintenance / Repairs	208,563	49,738	258,301	3,961	19,087	26,690
5	Plant Operations	374,974	140,032	515,006	5,407	50,127	72,449
6	Laundry and Linen	8,393	5,639	14,032	715		
7	Housekeeping	141,001	74,628	215,629	1,463	27,158	35,929
8	Cafeteria						
9	Dietary Services	247,059	168,755	415,814	17,083		
10	Maintenance of Personnel						
11	Nursing Administration	659,054	421,274	1,080,328	2,269	172,265	226,590
12	RN / LPN Education						
13	Medical Staff - Teaching	1,411,533	615,340	2,026,873	8,832	32,092	42,258
14	Post Graduate Medical Education						
15	Central Services & Supplies						
16	Pharmacy	254,795		254,795			
17	Medical Records	62,388	93,140	155,528	6,068	14,336	18,857
18	Medical Care Review	66,397	29,608	96,005	258	11,596	15,466
19	Social Services	1,645,043	950,571	2,595,614	3,259	377,411	540,969
20	Other Overhead (Specify)						
21	Subtotal Overhead	8,079,255	2,639,582	10,718,837	67,125	777,119	979,208
	Ancillary Care Services						
22	Surgery						
23	Labor & Delivery						
24	Recovery Room						
25	Anesthesiology						
26	Intravenous Therapy						
27	Medical Supplies - Special						
28	Drugs - Special				1,446		
29	Laboratory	26,880					
30	Blood						
31	Blood Processing / Storage						
32	Electrocardiology (EKG)	3,825					
33	Cardiac Cath Laboratory						
34	Diagnostic Radiology	3,157					
35	Therapeutic Radiology						
36	Computerized Tomography						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	2 Direct Exp (Sch IX, Col.13)	3 Allocated Expense	4 Total Exp for Stepdown	5 Bldg and Fixed Deprec	6 Fringe Benefits	7 Adminis-tration
37	Nuclear Medicine						
38	Respiratory Therapy						
39	Pulmonary Function Test						
40	Electroencephalography						
41	Electromyography						
42	Physical Therapy						
43	Occupational Therapy	103,610			4,580	26,566	34,943
44	Speech-Language Therapy						
45	Recreational Therapy	47,855			2,930		
46	Audiology						
47	Psychology / Psychiatry	121,492			873	31,831	41,881
48	Renal Dialysis						
49	Organ Acquisition						
50	Ambulance	1,079					
51	Vocational Education	2,224					103
52	Other Ancillary (Specify)						
53	Other Ancillary (Specify)						
54	Other Ancillary (Specify)						
55	Other Ancillary (Specify)						
56	Subtotal Ancillary	310,122			9,829	58,397	76,927
	Routine Inpatient Care Services						
57	Medical & Surgical Acute						
58	Pediatric Acute						
59	Obstetric Acute						
60	Psychiatric Acute	1,592,887			36,000	355,479	506,063
61	Ventilator Unit						
62	Skilled Nursing Facilities						
63	Other Acute (Specify)						
64	Other Acute (Specify)						
65	Other Acute (Specify)						
66	Subtotal Acute	1,592,887			36,000	355,479	506,063
	Med-Surg Intensive Care						
67	Med/Surg Intensive Care						
68	Coronary Intensive Care						
69	Neonatal Intensive Care						
70	Other ICU (Specify)						
71	Other ICU (Specify)						
72	Other ICU (Specify)						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	2 Direct Exp (Sch IX, Col.13)	3 Allocated Expense	4 Total Exp for Stepdown	5 Bldg and Fixed Deprec	6 Fringe Benefits	7 Adminis-tration
73	Other ICU (Specify)						
74	Other ICU (Specify)						
75	Subtotal Intensive Care						
76	Newborn Nursery						
76.01	Special Care Nursery						
77	Chronic / Rehabilitation						
78	Subtotal Routine Inpat Care	1,592,887			36,000	355,479	506,063
	Routine Ambulatory Care Services						
79	Emergency Services						
80	Clinic / Ambulatory Services	236,210			4,763	47,374	76,344
80.01	Clinic / Ambulatory Svcs (Specify)	236,210			4,763	47,374	76,344
81	Satellite Clinic Services						
82	Ambulatory Surgical Services						
83	Ambulatory Renal Dialysis						
84	Home Dialysis Services						
85	Psychiatry						
86	Home Health Services						
87	Observation Beds						
88	Private Referrals						
89	Hospital Licensed Health Centers						
90	PSYCH DAY TREATMENT	135,329			14,768	32,957	43,351
91	Other Ambulatory (Specify)						
92	Subtotal Routine Ambul Svcs	371,539			19,531	80,331	119,695
93	Total Patient Care	2,274,548			65,360	494,207	702,685
94	Total Pat Care & Overhead	10,353,803			132,485	1,271,326	1,681,893
	Non-Patient care Services						
95	Non-Patient Ancillary						
96	Research	1,495					
97	Other Non-Patient (Specify)	5,211			2,569		
97.02	CASE MANAGEMENT	202					
97.04	COMMUNITY MENTAL HEALTH	843			2,639		
97.06	Youth Mobile Crisis	1					
97.07	Gifts, Canteen, Coffee Shop	5,728					
97.21	PASTORAL SERVICES						
98	Subtotal Non-Patient	13,480			5,208		
99	Recovery of Expenses						
100	Total Patient/Non-Patient	10,367,283			137,693	1,271,326	1,681,893
101	Provision for Bad Debts						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	2 Direct Exp (Sch IX, Col.13)	3 Allocated Expense	4 Total Exp for Stepdown	5 Bldg and Fixed Deprec	6 Fringe Benefits	7 Adminis-tration
101.01	Gross Health Safety Net Assessment	1					
102	Total Patient/Non-Patient/Bad Debt/HSN	10,367,284			137,693	1,271,326	1,681,893

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	8 Plant Maint.& Repairs	9 Plant Operations	10 Laundry & Linen	11 House-keeping	12 Cafeteria	13 Dietary
	Overhead						
1	Buildings / Fixed Depreciation						
2	Fringe Benefits						
3	Administration						
4	Plant Maintenance / Repairs						
5	Plant Operations	12,049					
6	Laundry and Linen	1,593	3,331				
7	Housekeeping	3,260	6,818				
8	Cafeteria						
9	Dietary Services	38,064	79,607		34,001		
10	Maintenance of Personnel						
11	Nursing Administration	5,057	10,576		4,517		
12	RN / LPN Education						
13	Medical Staff - Teaching	19,681	41,159		17,580		
14	Post Graduate Medical Education						
15	Central Services & Supplies						
16	Pharmacy						
17	Medical Records	13,522	28,279		12,078		
18	Medical Care Review	574	1,201		513		
19	Social Services	7,261	15,185		6,486		
20	Other Overhead (Specify)						
21	Subtotal Overhead	101,061	186,156		75,175		
	Ancillary Care Services						
22	Surgery						
23	Labor & Delivery						
24	Recovery Room						
25	Anesthesiology						
26	Intravenous Therapy						
27	Medical Supplies - Special						
28	Drugs - Special	3,223	6,740		2,879		
29	Laboratory						
30	Blood						
31	Blood Processing / Storage						
32	Electrocardiology (EKG)						
33	Cardiac Cath Laboratory						
34	Diagnostic Radiology						
35	Therapeutic Radiology						
36	Computerized Tomography						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	8 Plant Maint.& Repairs	9 Plant Operations	10 Laundry & Linen	11 House-keeping	12 Cafeteria	13 Dietary
37	Nuclear Medicine						
38	Respiratory Therapy						
39	Pulmonary Function Test						
40	Electroencephalography						
41	Electromyography						
42	Physical Therapy						
43	Occupational Therapy	10,206	21,345		9,117		
44	Speech-Language Therapy						
45	Recreational Therapy	6,529	13,655		5,832		
46	Audiology						
47	Psychology / Psychiatry	1,945	4,068		1,737		
48	Renal Dialysis						
49	Organ Acquisition						
50	Ambulance						
51	Vocational Education						
52	Other Ancillary (Specify)						
53	Other Ancillary (Specify)						
54	Other Ancillary (Specify)						
55	Other Ancillary (Specify)						
56	Subtotal Ancillary	21,903	45,808		19,565		
	Routine Inpatient Care Services						
57	Medical & Surgical Acute						
58	Pediatric Acute						
59	Obstetric Acute						
60	Psychiatric Acute	80,212	167,757	14,032	71,649		415,814
61	Ventilator Unit						
62	Skilled Nursing Facilities						
63	Other Acute (Specify)						
64	Other Acute (Specify)						
65	Other Acute (Specify)						
66	Subtotal Acute	80,212	167,757	14,032	71,649		415,814
	Med-Surg Intensive Care						
67	Med/Surg Intensive Care						
68	Coronary Intensive Care						
69	Neonatal Intensive Care						
70	Other ICU (Specify)						
71	Other ICU (Specify)						
72	Other ICU (Specify)						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	8 Plant Maint.& Repairs	9 Plant Operations	10 Laundry & Linen	11 House-keeping	12 Cafeteria	13 Dietary
73	Other ICU (Specify)						
74	Other ICU (Specify)						
75	Subtotal Intensive Care						
76	Newborn Nursery						
76.01	Special Care Nursery						
77	Chronic / Rehabilitation						
78	Subtotal Routine Inpat Care	80,212	167,757	14,032	71,649		415,814
	Routine Ambulatory Care Services						
79	Emergency Services						
80	Clinic / Ambulatory Services	10,614	22,197		9,481		
80.01	Clinic / Ambulatory Svcs (Specify)	10,614	22,197		9,481		
81	Satellite Clinic Services						
82	Ambulatory Surgical Services						
83	Ambulatory Renal Dialysis						
84	Home Dialysis Services						
85	Psychiatry						
86	Home Health Services						
87	Observation Beds						
88	Private Referrals						
89	Hospital Licensed Health Centers						
90	PSYCH DAY TREATMENT	32,906	68,819		29,393		
91	Other Ambulatory (Specify)						
92	Subtotal Routine Ambul Svcs	43,520	91,016		38,874		
93	Total Patient Care	145,635	304,581	14,032	130,088		415,814
94	Total Pat Care & Overhead	246,696	490,737	14,032	205,263		415,814
	Non-Patient care Services						
95	Non-Patient Ancillary						
96	Research						
97	Other Non-Patient (Specify)	5,724	11,970		5,113		
97.02	CASE MANAGEMENT						
97.04	COMMUNITY MENTAL HEALTH	5,881	12,299		5,253		
97.06	Youth Mobile Crisis						
97.07	Gifts, Canteen, Coffee Shop						
97.21	PASTORAL SERVICES						
98	Subtotal Non-Patient	11,605	24,269		10,366		
99	Recovery of Expenses						
100	Total Patient/Non-Patient	258,301	515,006	14,032	215,629		415,814
101	Provision for Bad Debts						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	8 Plant Maint.& Repairs	9 Plant Operations	10 Laundry & Linen	11 House-keeping	12 Cafeteria	13 Dietary
101.01	Gross Health Safety Net Assessment						
102	Total Patient/Non-Patient/Bad Debt/HSN	258,301	515,006	14,032	215,629		415,814

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	14 Main-tenance of Personnel	15 Nursing Adminis-tration	16 RN and LPN Education	17 Medical Staff - Teaching	18 Post Grad Medical Education	19 Central Service & Supplies
	Overhead						
1	Buildings / Fixed Depreciation						
2	Fringe Benefits						
3	Administration						
4	Plant Maintenance / Repairs						
5	Plant Operations						
6	Laundry and Linen						
7	Housekeeping						
8	Cafeteria						
9	Dietary Services						
10	Maintenance of Personnel						
11	Nursing Administration						
12	RN / LPN Education						
13	Medical Staff - Teaching		453,738				
14	Post Graduate Medical Education						
15	Central Services & Supplies						
16	Pharmacy						
17	Medical Records						
18	Medical Care Review						
19	Social Services						
20	Other Overhead (Specify)						
21	Subtotal Overhead		453,738				
	Ancillary Care Services						
22	Surgery						
23	Labor & Delivery						
24	Recovery Room						
25	Anesthesiology						
26	Intravenous Therapy						
27	Medical Supplies - Special						
28	Drugs - Special						
29	Laboratory						
30	Blood						
31	Blood Processing / Storage						
32	Electrocardiology (EKG)						
33	Cardiac Cath Laboratory						
34	Diagnostic Radiology						
35	Therapeutic Radiology						
36	Computerized Tomography						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	14 Main-tenance of Personnel	15 Nursing Adminis-tration	16 RN and LPN Education	17 Medical Staff - Teaching	18 Post Grad Medical Education	19 Central Service & Supplies
37	Nuclear Medicine						
38	Respiratory Therapy						
39	Pulmonary Function Test						
40	Electroencephalography						
41	Electromyography						
42	Physical Therapy						
43	Occupational Therapy						
44	Speech-Language Therapy						
45	Recreational Therapy						
46	Audiology						
47	Psychology / Psychiatry						
48	Renal Dialysis						
49	Organ Acquisition						
50	Ambulance						
51	Vocational Education						
52	Other Ancillary (Specify)						
53	Other Ancillary (Specify)						
54	Other Ancillary (Specify)						
55	Other Ancillary (Specify)						
56	Subtotal Ancillary						
	Routine Inpatient Care Services						
57	Medical & Surgical Acute						
58	Pediatric Acute						
59	Obstetric Acute						
60	Psychiatric Acute		475,344		1,236,392		
61	Ventilator Unit						
62	Skilled Nursing Facilities						
63	Other Acute (Specify)						
64	Other Acute (Specify)						
65	Other Acute (Specify)						
66	Subtotal Acute		475,344		1,236,392		
	Med-Surg Intensive Care						
67	Med/Surg Intensive Care						
68	Coronary Intensive Care						
69	Neonatal Intensive Care						
70	Other ICU (Specify)						
71	Other ICU (Specify)						
72	Other ICU (Specify)						

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COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11
Stepdown Expenses (Including Capital)		**Schedule XV**

Line No.	Cost Center Description	14 Main-tenance of Personnel	15 Nursing Adminis-tration	16 RN and LPN Education	17 Medical Staff - Teaching	18 Post Grad Medical Education	19 Central Service & Supplies
73	Other ICU (Specify)						
74	Other ICU (Specify)						
75	Subtotal Intensive Care						
76	Newborn Nursery						
76.01	Special Care Nursery						
77	Chronic / Rehabilitation						
78	Subtotal Routine Inpat Care		475,344		1,236,392		
	Routine Ambulatory Care Services						
79	Emergency Services						
80	Clinic / Ambulatory Services				689,137		
80.01	Clinic / Ambulatory Svcs (Specify)				689,137		
81	Satellite Clinic Services						
82	Ambulatory Surgical Services						
83	Ambulatory Renal Dialysis						
84	Home Dialysis Services						
85	Psychiatry						
86	Home Health Services						
87	Observation Beds						
88	Private Referrals						
89	Hospital Licensed Health Centers						
90	PSYCH DAY TREATMENT		151,246		101,344		
91	Other Ambulatory (Specify)						
92	Subtotal Routine Ambul Svcs		151,246		790,481		
93	Total Patient Care		626,590		2,026,873		
94	Total Pat Care & Overhead		1,080,328		2,026,873		
	Non-Patient care Services						
95	Non-Patient Ancillary						
96	Research						
97	Other Non-Patient (Specify)						
97.02	CASE MANAGEMENT						
97.04	COMMUNITY MENTAL HEALTH						
97.06	Youth Mobile Crisis						
97.07	Gifts, Canteen, Coffee Shop						
97.21	PASTORAL SERVICES						
98	Subtotal Non-Patient						
99	Recovery of Expenses						
100	Total Patient/Non-Patient		1,080,328		2,026,873		
101	Provision for Bad Debts						

COMPU-MAX KPMG

Compu-Max D403 Provider Number: 2842 Provider Name: CAPE COD AND ISLANDS MENTAL HEALTH CENTER	Period From: 07/01/2013 To: 06/30/2014	Date: 01/20/2015 Time: 15:49:30 Version: 2014.11

Stepdown Expenses (Including Capital) — **Schedule XV**

Line No.	Cost Center Description	14 Main-tenance of Personnel	15 Nursing Adminis-tration	16 RN and LPN Education	17 Medical Staff - Teaching	18 Post Grad Medical Education	19 Central Service & Supplies
101.01	Gross Health Safety Net Assessment						
102	Total Patient/Non-Patient/Bad Debt/HSN		1,080,328		2,026,873		

Exhibit 21: Vinfen Contract for CCS

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

This form is jointly issued and published by the Executive Office for Administration and Finance (ANF), the Office of the Comptroller (CTR) and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. Any changes to the official printed language of this form shall be void. Additional non-conflicting terms may be added by Attachment. Contractors may not require any additional agreements, engagement letters, contract forms or other additional terms as part of this Contract without prior Department approval. Click on hyperlinks for definitions, instructions and legal requirements that are incorporated by reference into this Contract. An electronic copy of this form is available at www.mass.gov/osc under Guidance For Vendors - Forms or www.mass.gov/osd under OSD Forms.

CONTRACTOR LEGAL NAME: Vinfen Corporation (and d/b/a):	COMMONWEALTH DEPARTMENT NAME: Department of Mental Health MMARS Department Code: DMH
Legal Address: (W-9, W-4,T&C): 950 Cambridge Street, Cambridge, MA 02141	Business Mailing Address: 167 Lyman Street, Westborough, MA 01581
Contract Manager: Darlene Tritto	Billing Address (if different):
E-Mail: trittod@vinfen.org	Contract Manager: Denise Arsenault
Phone: (617) 441-1844 Fax: (617) 441-1858	E-Mail: Denise.Arsenault@state.ma.us
Contractor Vendor Code: VC6000164821	Phone: 508-897-2086 Fax: 508-616-2130
Vendor Code Address ID (e.g. "AD001"): AD 001 . (Note: The Address Id Must be set up for EFT payments.)	MMARS Doc ID(s): SCDMH535001352190000 RFR/Procurement or Other ID Number: Interim

___ NEW CONTRACT	X CONTRACT AMENDMENT
PROCUREMENT OR EXCEPTION TYPE: (Check one option only) __ Statewide Contract (OSD or an OSD-designated Department) __ Collective Purchase (Attach OSD approval, scope, budget) __ Department Procurement (includes State or Federal grants 815 CMR 2.00) (Attach RFR and Response or other procurement supporting documentation) __ Emergency Contract (Attach justification for emergency, scope, budget) __ Contract Employee (Attach Employment Status Form, scope, budget) __ Legislative/Legal or Other: (Attach authorizing language/justification, scope and budget)	Enter Current Contract End Date *Prior* to Amendment: June 30 , 20 14 . Enter Amendment Amount: $ 890,741.64 . (or "no change") AMENDMENT TYPE: (Check one option only. Attach details of Amendment changes.) __ Amendment to Scope or Budget (Attach updated scope and budget) __ Interim Contract (Attach justification for Interim Contract and updated scope/budget) __ Contract Employee (Attach any updates to scope or budget) X Legislative/Legal or Other: (Attach authorizing language/justification and updated scope and budget)

The following COMMONWEALTH TERMS AND CONDITIONS (T&C) has been executed, filed with CTR and is incorporated by reference into this Contract.
__ Commonwealth Terms and Conditions X Commonwealth Terms and Conditions For Human and Social Services

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.
__ Rate Contract (No Maximum Obligation. Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)
X Maximum Obligation Contract Enter Total Maximum Obligation for total duration of this Contract (or *new* Total if Contract is being amended). $ 2,455,474.73 .

PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within 10 days __% PPD; Payment issued within 15 days __ % PPD; Payment issued within 20 days __ % PPD; Payment issued within 30 days __% PPD. If PPD percentages are left blank, identify reason: __agree to standard 45 day cycle X statutory/legal or Ready Payments (G.L. c. 29, § 23A); __ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.)
Exercise option to renew services for Fiscal Year 2015.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:
_ 1. may be incurred as of the Effective Date (latest signature date below) and no obligations have been incurred prior to the Effective Date.
X 2. may be incurred as of July 1 , 20 14 , a date LATER than the Effective Date below and no obligations have been incurred prior to the Effective Date.
__3. were incurred as of ____, 20____ , a date PRIOR to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of 6/30 , 20 15 , with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor makes all certifications required under the attached Contractor Certifications (incorporated by reference if not attached hereto) under the pains and penalties of perjury, agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form including the Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:	AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:
X: Glen Mattera Date: 6/20/14 (Signature and Date Must Be Handwritten At Time of Signature)	X: Howard Baker Smith Date: 6/26/14 (Signature and Date Must Be Handwritten At Time of Signature)
Print Name: Glen Mattera	Print Name: HOWARD BAKER SMITH
Print Title: Chief Financial Officer	Print Title: AREA DIRECTOR

Exhibit 22: Pocasset Contract (for Lease)

THIS OFFICIAL FORM MAY NOT BE ALTERED. ANY CHANGES OR ALTERATIONS MADE TO THIS FORM MAY RESULT IN DISQUALIFICATION OF THE PROPOSAL.

LEASE PROPOSAL

User Agency: **Department of Mental Health** Project No.: **201522000.1**

To: Director, Office of Leasing and State Office Planning
Division of Capital Asset Management and Maintenance
One Ashburton Place, 14th Floor – Room 1411
Boston, Massachusetts 02108

The undersigned has read the Request for Proposals (RFP) and has carefully examined all specifications within the RFP. The undersigned acknowledges that the proposed property must comply with all RFP specifications before occupancy by the User Agency unless unambiguously stated otherwise in this Proposal, the undersigned is an eligible proposer as defined in the RFP and there are no known obstacles to prevent the owner from executing a lease or that could invalidate such lease. The undersigned confirms that the owner of the proposed property will 1) enter into a lease substantially in the form of the lease document attached to the RFP, 2) provide a statement under oath listing the names and addresses of all persons having a direct or indirect beneficial interest in the property, as required by G. L. chapter 7C, § 38, 3) provide a certification that all state taxes and employment-security contributions have been paid by the owner in accordance with G. L. chapter 62C, § 49A and chapter 151A, § 19A (b), and 4) execute under oath a Certificate of Compliance with Executive Order No. 481 (the official forms for items 2), 3), and 4) of this sentence immediately follow the official lease-document form that is referenced in item 1) of this sentence). The undersigned acknowledges that DCAMM may reject all proposals, or waive portions of the RFP for all proposals if DCAMM deems such rejection, waiver, or both to be in the Commonwealth's best interests. The undersigned proposes to lease property to the Commonwealth of Massachusetts as follows:

1. Proposal Summary

1.1. Location and Search Area:

Address of Proposed Building: **270 Communication Way, Building 6,**
Floor No.: **1**
City: **Hyannis** State: **MA** Zip Code: **02601**
Confirm that the proposed Building is located within the search area defined in the RFP. ☒ Yes ☐ No

1.2. Usable Area
Proposed Usable Area: **5,138** USF (see RFP § 4.5 for definition of "Usable Area")
Existing Use:

1.3. Commonwealth Lease and Term

Proposed Term of Lease **10** Years (see RFP § 1.3)
Confirm that the proposed landlord will enter into a lease substantially in the form of the Commonwealth Lease attached to the RFP without material modification. ☒ Yes ☐ No
Please attach a separate sheet identifying all proposed revisions.

1.4. Proposer

DCAMM
APR 06 2015
OFFICE OF LEASING

Name of Proposer: **Stuart Bornstein**
Contact: **Edward Mackay 508-776-3104**
Company Name: **Hyannis Office Park Center, LLC**
Proposer's Address: **297 North Street** Tel: **508-775-9316**
City: **Hyannis** State: **MA** Zip Code: **02601** Fax: **508-775-6526**
E-mail: **vintage@cape.com**
Proposer is submitting this proposal as (see RFP § 4.3 for definition of "Eligible Proposer"):
☒ Record Owner ☐ Broker or Agent ☐ Prospective Purchaser ☐ Tenant whose lease permits subleasing

Proposer represents and warrants that 1) the information and statements in this Proposal are complete and accurate to the best of the Proposer's ability to make them so, and 2) the Proposer has not communicated with any representative of the Commonwealth of Massachusetts regarding preparation of this Proposal other than the DCAMM Project Manager.

Proposer's Signature: _____ **Date:** 5/1/15

1.5. Property Owner

Name: **Hyannis Office Park Center, LLC** Name of Principal(s): **Stuart Bornstein**
Address: **297 North Street** Tel: **508-775-9316**

City: **Hyannis** State: **MA** Zip Code: **02601** E-mail: **tbusby@hollymanagement.com**

2. Cost

Complete the Table below by filling in the components of the proposed Total Annual Rent for each year of the lease term and identify the estimated amount for Landlord's Improvements that is included in the proposed Total Annual Rent. Please complete the Table using total dollars/year; DCAMM will confirm the usable area of the proposed Premises to arrive at a rate/usf.

The far-left column identifies components of the Annual Rent. If one or more component is excluded from the proposed Total Annual Rent, write "Excluded" in the appropriate boxes in that row. If one or more component is included within another component, write "Included" in the appropriate boxes in that row. Confirm that amounts are entered in the appropriate box so that the Total Annual Rent equals the sum of the amounts entered.

Under "Comments," please provide information about excluded costs and any other costs that require explanation.

DCAMM encourages submission of gross flat-rent proposals that include the cost of all Landlord's Improvements and Landlord's Services.

Include *all* cost information for the proposal on this page.

Annual Rent ($/yr)	Year 1	Year 2	Year 3	Year 4	Year 5
Base Amount for Rent:	77,070	78,611	80,183	81,787	83,423
Amount for Janitorial Services:	10,000	10,200	10,404	10,612	10,824
Amount for Lights and Plugs:	0	0	0	0	0
Amount for Reserved Parking:	0	0	0	0	0
Amount for Other: Taxes	8,115	8,277	8,443	8,612	8,784
Amount for Other: CAM w/gen&alarm maint&serv	18,087	18,449	18,818	19,194	19,578
Amount for Other: Amortized improvements6%/10yrs	55,954	55,954	55,954	55,954	55,954
Total Annual Rent:	169,226	171,491	173,802	176,159	178,563

Annual Rent ($/yr)	Year 6	Year 7	Year 8	Year 9	Year 10
Base Amount for Rent:	85,091	86,793	88,529	90,300	92,106
Amount for Janitorial Services:	11,040	11,261	11,486	11,716	11,950
Amount for Lights and Plugs:	0	0	0	0	0
Amount for Reserved Parking:	0	0	0	0	0
Amount for Other: Taxes	8,960	9,139	9,322	9,508	9,698
Amount for Other: CAM w/gen&alarm maint&serv	19,970	20,369	20,776	21,192	21,616
Amount for Other: Amortized improvements6%/10yrs	55,954	55,954	55,954	55,954	55,954
Total Annual Rent:	181,015	183,516	186,067	188,770	191,324

Estimated amount for Landlord's Improvements (see section B of RFP) included in the Total Annual Rent: $ 55,954

Comments:
THIS IS OPTION #1 with ALL THE IMPROVEMENTS REQUESTED IN BID.

City: **Hyannis** State: **MA** Zip Code: **02601** E-mail: **tbusby@hollymanagement.com**

2. Cost

Complete the Table below by filling in the components of the proposed Total Annual Rent for each year of the lease term and identify the estimated amount for Landlord's Improvements that is included in the proposed Total Annual Rent. Please complete the Table using total dollars/year; DCAMM will confirm the usable area of the proposed Premises to arrive at a rate/usf.

The far-left column identifies components of the Annual Rent. If one or more component is excluded from the proposed Total Annual Rent, write "Excluded" in the appropriate boxes in that row. If one or more component is included within another component, write "Included" in the appropriate boxes in that row. Confirm that amounts are entered in the appropriate box so that the Total Annual Rent equals the sum of the amounts entered.

Under "Comments," please provide information about excluded costs and any other costs that require explanation.

DCAMM encourages submission of gross flat-rent proposals that include the cost of all Landlord's Improvements and Landlord's Services.

Include *all* cost information for the proposal on this page.

Annual Rent ($/yr)	Year 1	Year 2	Year 3	Year 4	Year 5
Base Amount for Rent:	77,070	78,611	80,183	81,787	83,423
Amount for Janitorial Services:	10,000	10,200	10,404	10,612	10,824
Amount for Lights and Plugs:	0	0	0	0	0
Amount for Reserved Parking:	0	0	0	0	0
Amount for Other: Taxes	8,115	8,277	8,443	8,612	8,784
Amount for Other: CAM w/gen&alarm maint&serv	18,087	18,449	18,818	19,194	19,578
Amount for Other: Amortized improvements6%/10yrs	22,648	22,648	22,648	22,648	22,648
Total Annual Rent:	135,920	138,185	140,496	142,853	145,257

Annual Rent ($/yr)	Year 6	Year 7	Year 8	Year 9	Year 10
Base Amount for Rent:	85,091	86,793	88,529	90,300	92,106
Amount for Janitorial Services:	11,040	11,261	11,486	11,716	11,950
Amount for Lights and Plugs:	0	0	0	0	0
Amount for Reserved Parking:	0	0	0	0	0
Amount for Other: Taxes	8,960	9,139	9,322	9,508	9,698
Amount for Other: CAM w/gen&alarm maint&serv	19,970	20,369	20,776	21,192	21,616
Amount for Other: Amortized improvements6%/10yrs	22,648	22,648	22,648	22,648	22,648
Total Annual Rent:	147,709	150,210	152,761	155,464	158,018

Estimated amount for Landlord's Improvements (see section B of RFP) included in the Total Annual Rent: $ 22,648

Comments:
THIS IS OPTION #2 with the items included as aa attachment. THIS OPTION OFFERS A JULY OCCUPANCY.

Form 3 Notes

Contract Price

The Contract price is composed of two primary components. The first is the incremental increase in the per member per month (PMPM) payments made to MassHealth's managed care companies as a result of the proposed privatization. The second is the increase in the interagency service agreement (ISA), a yearly transfer of funds from DMH to MassHealth for the purpose of compensating the state's managed care companies for providing services to the uninsured.

MassHealth and its actuary partner developed estimates of the marginal increases in the PMPM paid to MassHealth managed care companies should the proposed privatization be completed. All marginal PMPM increases were calculated using contract year 4 (CY4) and Revenue Year 16 (RY) data. These costs are included in Exhibit 23.

The program actuaries identified the two applicable population rating categories (RC I and RC II) likely to be impacted by the proposed privatization across MBHP, the state's Managed Care program and CarePlus programs:

- Rating Category 1 (RC I): Includes all Temporary Assistance to Need Families (TANF) and excludes children with a third party liability (TPL) payer
- Rating Category II (RC II): Includes all disabled members, those with supplemental security income (SSI) and those on supplemental security disability insurance (SSDI)
- Rating Category IX (RCIX): Includes individuals ages 21 through 64 with incomes up to 133% federal poverty level (FPL), who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage.
- Rating Category X (RC X): includes individuals ages 21 through 64 with incomes up to 133% FPL, who are not pregnant, disabled, a parent or caretaker relative of a child under age 19, or eligible for other EOHHS coverage, who are also receiving emergency assistance to elderly, disabled, and children (EAEDC) through the Massachusetts Department of Transitional Assistance.

The overall costs associated with these various categories are summarized below:

Program	***Risk Category***	***Dollar Adj***
MBHP	RC I and II	$1,913,191
MCO	RC I and II	$1,155,891
CarePlus	RC IX and X	$341,591

To account for costs associated with providing services to the uninsured and other special populations currently serviced by DMH SE ESPs, the ISA is also scheduled to increase in total dollar amount between DMH and MassHealth.

In order to identify the needed increase in the ISA, dollar amounts were estimated for all services provided by the ESP locations (including MCI services and community crisis stabilization services) across two populations: the uninsured and those deemed as fee-for-service patients (individuals who are insured through non MCO MassHealth service as well as certain individuals who are dually enrolled in both Medicare and Medicaid).

In order to determine the dollar amounts associated with the uninsured population, two separate calculations were completed to estimate costs associated with CCS and non-CCS encounters. Over the previous 12 months, the four SE ESP locations provided services across 504 non-CCS encounters to uninsured individuals. The FFS Medicaid reimbursement level of $488.00 per non-CCS encounter was used to determine the direct costs associated with providing these services: $245,952.

These uninsured encounters represented 4% of total non-CCS encounters. This proportion was then used as a proxy for estimating the total CCS bed days likely associated with the uninsured. The average daily census for CCS across all payers for the previous year within the SE ESP region was 7,161. Four percent of this number equates to an estimated 289 bed days associated with the uninsured. These bed days were then multiplied by the average FFS reimbursement rate of $488 for an estimated future total of $386,746 in yearly CCS bed day expense associated with the uninsured.

The final component of the ISA includes the estimated costs associated with the FFS population currently receiving care through the SE ESP services. Last year this included 3,729 total encounters. Similarly, this total was multiplied by the FFS rate of $488 per encounter for an additional expected expense of $1,819,752.

Both of these populations (uninsured and FFS) were totaled to determine the expected increase in the ISA needed following the privatization: $2,206,498.

Contract Administration

Contract Administration is expected to be immaterial given the number of ESP beneficiaries that will transition away from DMH care into other providers relative to the rest of MassHealth's current population. The actuarial analysis provided by MassHealth indicated that due to this relative marginal increase in services, the administrative fee would not need to materially change within the PMPM payments to its MCEs.

Transition Costs

The third piece of the Contract Performance Costs are the transition costs. These costs are an estimation of the amount that would be spent in order to transition the state-run Emergency Service Programs to privately run facilities. Several factors go into this calculation, including unemployment benefits, retirement benefits, disposal of assets, and other savings or costs.

Unemployment Benefits

In transitioning the ESPs, DMH would be required to lay off all current employees, and in doing so, would be required to provide state-mandated unemployment benefits to all employees. An analysis was performed to determine the full extent of these unemployment costs based on current staff data and determined that DMH would be required to pay $954,158 in unemployment benefits.

The state determines unemployment benefits by calculating the amount an employee received during the past four quarters, selecting the two quarters with the highest earnings, and calculating a weekly wage based on that amount. The amount is then halved and rounded to the nearest dollar to determine the weekly benefit amount an employee can receive through unemployment benefits. However, this amount is capped at a rate of $698/week. This calculation was conducted for each of the four facilitiesto determine each individual employee's expected weekly unemployment benefit

amount. The maximum number of weeks the state will provide benefits is 30; however, many employees will qualify for less than 30 weeks of unemployment benefits.[11] In addition, it is probable that many of these employees will be employed by the newly privatized facility. As a result of these two assumption factors, 15 weeks is used as the average length of time an employee will receive benefits.

Once this calculation for the total estimated accrued benefits was complete, an adjustment was made to reflect the personnel changes made in the management study including a reduction of 6 FTEs (partial FTEs were not included in the calculation of unemployment benefits). For the positions affected in the management study, an average per FTE benefits amount was calculated and the change was applied to the total estimated accrued benefits.

Lastly, estimations were made as to the number of dependent children that employees of the facility may have, since employees may qualify for an additional $25 per week per dependent child. For this estimation, statewide demographics from November 2014 were used.[12] According to this data, 30.6% of households had a dependent child, and the average family household size was 3.15. The project team took 30.6% of the total number of eligible staff and multiplied that number by 1.15, which is average number of dependent children in a household, assuming two spouses. The overview of this calculation is provided in the table below:

Unemployment Benefit Calculation

Facility Name	**Sum Weekly Expenses**
Brockton	$289,148
Norton	$298,485
Cape & Islands	$171,476
Corrigan	$251,681
Total	**$1,010,792**
Management Study Adj.*	($71,282)
Net Est. Accrued Benefits	$939,510
Additional Benefits	$14,648
Total Unemp. Benefits	**$954,158**

*Management Study Calculation**

Position	**Per FTE Avg Benefit**	**Net FTE Change^**	**Cost Adjustment**
Human Services Coordinator (C)	$9,417.78	(7)	($65,924)
Clinical Social Worker A/B	$9,558.63	(1)	($9,559)
Clinical Social Worker C	$10,265.71	2	$20,531
Registered Nurse II	$10,470.00	(5)	($52,350)
Licensed Practical Nurse II	$7,204.02	5	$36,020
	Totals:	(6)	**($71,282)**

^Rounded down to nearest whole as those < 1 FTE are not eligible for benefits

[11] http://www.mass.gov/lwd/unemployment-insur/basic-ui-information/initial-claim/how-your-benefits-are-determined/calculating-benefit-rate.html

[12] http://www.newtonma.gov/gov/planning/demog/

Several assumptions were made that could potentially affect the final outcome of this calculation. Working with the salary data available, which included the annual salary amount of the employees, weekly wages were estimated off of this salary data and then divided by 50% to determine one-half of the employee's weekly payment. In actuality, the weekly amount is determined using the two highest earning quarters of the employee, so there is some potential for volatility based on this estimation. In addition, only full time employees were considered eligible for this calculation. As the data used to determine full time employees was from a single point in time, this FTE count has the potential to fluctuate.

Retirement Benefits

For the second component of transition costs, retirement benefits, it is assumed that all remaining employees will not be eligible to receive these benefits. It is presumed that those employees who would have been eligible for retirement benefits would have previously left the facility as the Commonwealth recently put forth an early retirement option for eligible employees and thus the cost impact is negligible.

Other Transition Costs

The other transition costs category includes the lease of the Norton ESP site containing clinicians and the Community Crisis Stabilization unit as well as the lease of space for Cape's Community Crisis Stabilization unit. Assuming that DMH acts in good faith in terminating the contracts and provides a 60- day notice in writing, there will be no additional costs incurred for terminating the leases referenced. Also included in this category is $60,000 in transition assistance provided by DMH to the winning bidder to assist with transitioning the program swiftly and effectively.

Gain or Loss on Asset Disposal

There will be no gain or loss on the disposal of assets as there will be no resulting elimination of any large assets or buildings. The Brockton, Fall River, and Pocasset ESP programs are located in state owned buildings that house multiple services. These assets would remain should the ESP program cease to operate in this space. The Fall River CCS is in a DMH-owned residence that will be repurposed for existing community programs if the CCS unit were to close.

Lost Tax Revenue

Both vendors selected through the procurement process are based inside the Commonwealth of Massachusetts. As such, it is assumed for the purposes of this analysis that the State will not lose any tax revenue due to out of state operations.

State Income Tax

Both vendors chosen through the procurement process are classified as IRS 501(c)3 tax-exempt entities and therefore not subject to state income taxes.

Exhibit 23: Commonwealth of Massachusetts Summary of ESP Projected Costs

Dollars		Effective 10/1/15		
Program	**RC**	**ESP**	**CCS**	**Total**
MBHP	RC I	$ 136,819	$ 450,194	$ 587,013
MBHP	RC II	$ 275,382	$ 1,050,797	$ 1,326,179
MBHP	**All**	**$ 412,201**	**$ 1,500,991**	**$ 1,913,192**
MCO	RC I	$ 132,332	$ 279,681	$ 412,013
MCO	RC II	$ 232,026	$ 511,852	$ 743,878
MCO	**All**	**$ 364,358**	**$ 791,533**	**$ 1,155,891**
CarePlus	RC IX	$ 97,725	$ 185,874	$ 283,600
CarePlus	RC X	$ 15,628	$ 42,363	$ 57,991
CarePlus	**All**	**$ 113,353**	**$ 228,238**	**$ 341,591**

PMPM		Effective 10/1/15		
Program	**RC**	**ESP**	**CCS**	**Total**
MBHP	RC I	$ 0.04	$ 0.12	$ 0.15
MBHP	RC II	$ 0.35	$ 1.34	$ 1.69
MBHP	**All**	**$ 0.09**	**$ 0.33**	**$ 0.42**
MCO	RC I	$ 0.11	$ 0.24	$ 0.35
MCO	RC II	$ 1.59	$ 3.51	$ 5.10
MCO	**All**	**$ 0.28**	**$ 0.60**	**$ 0.88**
CarePlus	RC IX	$ 0.16	$ 0.31	$ 0.47
CarePlus	RC X	$ 0.99	$ 2.68	$ 3.67
CarePlus	**All**	**$ 0.18**	**$ 0.37**	**$ 0.55**

Exhibit 24: Commonwealth of Massachusetts Interdepartmental Service Agreement (ISA) Form

MMARS DOCUMENT ID: ISA_DMHJOINTESPEHS16B

COMMONWEALTH OF MASSACHUSETTS
INTERDEPARTMENTAL SERVICE AGREEMENT (ISA) FORM

This Form is issued and published by the Office of the Comptroller (CTR) pursuant to 815 CMR 6.00 for use by all Commonwealth Departments. Departments may add non-conflicting additional terms, but changes to the official printed language of this Form shall be void.

BUDGET FISCAL YEAR: 2016	RFR REFERENCE NUMBER ENTER RFR NUMBER: OR _X_ N/A.
MMARS ALPHA *BUYER/PARENT* DEPARTMENT CODE: DMH	MMARS ALPHA *SELLER/CHILD* DEPARTMENT CODE: EHS
BUSINESS MAILING ADDRESS: **25 STANIFORD ST., BOSTON, MA 02114**	BUSINESS MAILING ADDRESS: 1 ASHBURTON PLACE – ROOM 1109; BOSTON, MA 02108
ISA MANAGER: THUY-NHUNG NGUYEN	ISA MANAGER: EMILY SHERWOOD
PHONE: **617-626-8033** FAX: 617-626-8014	PHONE: **617-573-1759** FAX:
E-MAIL ADDRESS: THUY-NHUNG.NGUYEN@STATE.MA.US	E-MAIL ADDRESS: EMILY.SHERWOOD@STATE.MA.US

Purpose of ISA: (Check one option only and complete applicable information) (Attachment A required for New ISAs and all ISA Amendments.)

___ New ISA. Current Maximum Obligation for total duration of ISA $_____ (Use "N/A" for Non-Financial ISA.) (Complete Attachment B)

_X_ Amendment to Existing ISA. What is being amended? (Attachment C required for all Federal and Bond Account Amendments)

- _X_ Amend Budget/Accounts. Change Maximum Obligation from: $ **443,194,063.60** to New Maximum Obligation **$443,694,063.60** (Attachment B)
- ___ Amend Budget/Accounts. No Change in Maximum Obligation (Attachment B)
- ___ Amend Dates of Performance. New Dates of Service: Start Date: 7/1/04 End Date: 6/30/16 (Subject to execution dates below.)
- _X_ Amend Scope of Services/Performance

BRIEF DESCRIPTION OF PERFORMANCE GOALS TO BE ACCOMPLISHED BY ISA, OR IF AMENDMENT, IDENTIFY WHAT IS BEING AMENDED: FY16 ISA AMENDMENT

DMH is increasing the budget for MCPAP by $500,000 to expand MCPAP for Moms to full operational capacity statewide.

REIMBURSEMENT FOR MASSHEALTH BEHAVIORAL PROGRAM RESPONSIBILITIES PERFORMED BY ITS BEHAVIORAL HEALTH VENDOR (MBHP)

WILL SELLER/CHILD DEPARTMENT STATE EMPLOYEES (AA OBJECT CLASS) BE FULLY OR PARTIALLY FUNDED UNDER THIS ISA? _X_ **No** ___ **Yes.** If Yes, Seller/Child certifies that the ISA is not being used as an alternative funding mechanism for state employees, that the identified personnel in Attachment A are necessary for completion of the ISA due to particular expertise or other factors that can not be obtained through the use of contractors, and that if federal funds are being used, funds shall not be used to supplement the regular salary or compensation of any officer or employee of the Commonwealth for services performed during their regular working hours. M.G.L. c. 29, § 6B.

ACCOUNT INFORMATION. Complete for all new ISAs and Amendments (even if account information is not changing) Check one option, indicate "add", "delete" or "no change" and enter account, fund, major program code and program code.

___ BGCN – non-subsidiarized (federal, capital, trust). Attachment C required for any new ISA or ISA Amendment involving federal funds.

_X_ BGCS – subsidiarized (budgetary)

___ Other (CT, RPO as authorized by CTR): _____

___ Non-Financial ISA (no funds are transferred from Buyer/Parent to Seller/Child), however, resources are committed to ISA.

___ Amendment with no Accounting Changes to Budget/Accounts or to Attachments B or C. (Indicate no change below and complete account information.)

___ ADD ___ DELETE _X_ NO CHANGE	Account:50470001	Fund: 0010	Major Program Code:	Program Code:
___ ADD ___ DELETE _X_ NO CHANGE	Account:50425000	Fund:0010	Major Program Code:	Program Code:
___ ADD ___ DELETE _X_ NO CHANGE	Account:30002010	Fund:0100	Major Program Code:RTTELC	Program Code:FFY12RTTEL
___ ADD ___ DELETE ___ NO CHANGE	Account:	Fund:	Major Program Code:	Program Code:

ISA ANTICIPATED START DATE: provided that the Seller/Child certifies that it will not incur any obligations related to this ISA prior to the date that this ISA is executed, NOR prior to the date that sufficient funding for the obligations for this ISA is available in the Seller/Child account for expenditure.

TERMINATION DATE OF THIS ISA: This ISA shall terminate on **06/30/2016** unless terminated or properly amended in writing by the parties prior to this date.

BUYER/PARENT AND SELLER/CHILD DEPARTMENT CERTIFICATIONS. IN WITNESS WHEREOF, by executing this ISA below, the Buyer/Parent and Seller/Child certify, under the pains and penalties of perjury, that Buyer/Parent and Seller/Child understand and agree that any Buyer/Parent or Seller/Child officer or employee who knowingly violates, authorizes or directs another officer or employee to violate any provision of state finance law relating to the incurring of liability or expenditure of public funds, includng this ISA, may be considered to be in violation of M.G.L. c. 29, § 66, and therefore the Buyer/Parent and the Seller/Child agree to ensure that this ISA complies with, and that all staff or contractors involved with ISA performance are provided with sufficient training and oversight to ensure compliance with 815 CMR 6.00, CTR applicable policies and the ISA Terms and Conditions which are incorporated by reference into this ISA, in addition to the performance requirements identified in Attachment A of this ISA, and that all terms governing performance of this ISA are attached to this ISA or incorporated by reference herein, and the Buyer/Parent and Seller/Child agree to maintain the necessary level of communication (including immediate notification of any amendments to accounting information, program codes or performance needs), coordination, access to reports and other ISA information, and cooperation to ensure the timely execution and successful completion of the ISA, amendments, and state finance law compliance; and that the Buyer/Parent certifies it will ensure that sufficient funds are timely made available in the Seller/Child account(s), with the proper accounting codes, prior to the Seller/Child's need to begin initial or amended performance; and that the Seller/Child will not allow initial or amended performance to begin until the ISA is executed AND the ISA Seller/Child account is sufficiently funded to support encumbrances and payments for performance (including payroll), and the Seller/Child will make encumbrances and payments (including payroll) only from the authorized ISA Seller/Child account(s) and shall not be entitled to transfer charges made from any other account not approved in writing by CTR in advance of expenditures by the Seller/Child.

BUYER/PARENT DEPARTMENT'S AUTHORIZED SIGNATURE:	SELLER/CHILD DEPARTMENT'S AUTHORIZED SIGNATURE:
DATE: 10/7/15 (Date must be handwritten by signatory at time of signature)	DATE: 10-5-15 (Date must be handwritten by signatory at time of signature)
PRINT NAME: JIM BERGSTROM	PRINT NAME: DANIEL TSAI
PRINT TITLE: DIRECTOR OF ACCOUNTING AND OPERATIONS	PRINT TITLE: ASSISTANT SECRETARY FOR MASSHEALTH

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Issued 10/8/2005

INTERDEPARTMENTAL SERVICE AGREEMENT (ISA) FORM

ATTACHMENT A – TERMS OF PERFORMANCE AND JUSTIFICATIONS:

This Attachment Form must be used. Insert (type or copy and paste) all relevant information using as many pages as necessary. Attach any additional supporting documentation as appropriate. If Amending the ISA, completion of Sections 1, 2 and 3 identifying what is being amended and the reasons for the amendments is required. For sections 4-9 enter only the amended language in the sections being amended.

1. [REQUIRED] Purpose and other performance goals of ISA, or as amended:

   In FY'96 the Commonwealth's Medicaid agency and the Department of Mental Health (DMH) entered into a partnership to develop and implement a single integrated system of publicly funded mental health services. In pursuit of this goal, DMH and the Executive Office of Health and Human Services (EOHHS) (together, the Agencies) are parties to an Interdepartmental Service Agreement (ISA) under which DMH provides funds to EOHHS to pay the MassHealth PCC Plan's Behavioral Health Services Contractor (the Massachusetts Behavioral Health Partnership, or MBHP) for specified responsibilities that MBHP performs on behalf of DMH. MBHP's responsibilities to provide the DMH Specialty Program services set forth in this ISA are described in detail in the MassHealth PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs contract with EOHHS (document # 11LCEHSPCCPLANBHPMSSRFR).

   This is an amended and restated version of the ISA.

2. [REQUIRED] Identify in detail, the responsibilities of the parties, the scope of services and terms of performance under the ISA, or as amended:

   A. The Agencies

   DMH is the Commonwealth's mental health authority pursuant to M.G.L. c. 19 and M.G.L. c. 123, et seq. EOHHS is the executive agency within Massachusetts that is the single state agency responsible for the administration of the MassHealth program (Medicaid), pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto.

   EOHHS contracts with MBHP to provide care management services, network management services, quality management activities and comprehensive Behavioral Health services for certain MassHealth members. In addition, MBHP provides Emergency Service Programs Services for Uninsured Individuals and persons with Medicare coverage only and administrative oversight of DMH Specialty Programs on behalf of EOHHS and DMH.

   B. Definitions

   Behavioral Health Program (BHP) – a program for the administration, coordination, and delivery of mental health and substance use disorder Covered Services, as defined in Appendix A-1 of the Contract.

   Contract – The MassHealth PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs contract (document # 11LCEHSPCCPLANBHPMSSRFR), entered into by EOHHS and MBHP September 30, 2012, and as amended from time to time.

   Contractor (or **MBHP**) – the Massachusetts Behavioral Health Partnership, the vendor with which EOHHS contracts to perform the responsibilities specified in the Contract.

   DMH Case Management – a service operated by DMH which is performed in accordance with DMH regulations for DMH Clients. DMH Case Management includes those services enumerated in 104 CMR 29.00.

   DMH Clients –for purposes of this ISA, individuals who are eligible for and recipients of DMH Specialty Programs from the Contractor.

   DMH Continuing Care Services – community-based services contracted for or operated by DMH, but which do not include: services of brief duration; outpatient services; or acute mental health services, such as crisis intervention or emergency screening.

DMH Service Authorization – the process by which a MassHealth member is found to be eligible and approved for a service provided through DMH.

DMH Specialty Programs – programs the Contractor manages on behalf of DMH, including the Emergency Services Program (ESP) for Uninsured Individuals and persons covered by Medicare only, the Massachusetts Child Psychiatry Access Project (MCPAP), and Forensic Evaluations.

Designated Forensic Professional – a physician or psychologist designated by DMH as qualified to perform a clinical assessment of the mental status of a prisoner and provide recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment. See M.G.L. c. 123, § 18(a).

Emergency Service Programs (ESP) Services –the services described in the Contract, Appendix A-1, Part III and delivered by the providers identified in Contract Appendix A-3.

Forensic Evaluation Services – a clinical assessment of the mental status of a prisoner, performed by a physician or psychologist designated by DMH as qualified to perform such examination in accordance with M.G.L. c. 123, § 18(a). Such examination shall including recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment, if so indicated.

Massachusetts Child Psychiatry Access Project (MCPAP) – a DMH project whose primary goals are to improve access to treatment for children with psychiatric problems thereby promoting productive relationships between primary care and child psychiatry and rational utilization of scarce resources and to improve access to treatment for pregnant and postpartum women with depression and other mental health conditions. MCPAP consists of children's mental health consultation teams throughout the state to help primary care practitioners meet the needs of children with psychiatric problems. In addition, three MCPAP for Moms mental health consultation teams provide psychiatric consultation to obstetric and primary care providers to help them manage depression and other mental health concerns of their pregnant and postpartum patients.

Network Provider – an individual, group, facility, agency, institution, organization, or business under contract with MBHP that furnishes or has furnished medical services to DMH Clients.

Pre-Arraignment Protocol (PAP) – a protocol that sets forth a legal-clinical assessment process which allows local police departments to obtain psychiatric hospitalizations, where appropriate, for persons who are arrested but not yet arraigned when the court is closed.

Uninsured Individuals – those individuals who are not MassHealth or CommCare eligible for any reason, and do not have commercial insurance.

C. Agencies' Responsibilities Under the ISA

1. Joint Responsibilities

The Agencies are jointly responsible for:

a. Approving the level and types of Emergency Service Programs to be purchased by the Contractor and the scope of the other DMH Specialty Programs (MCPAP and Forensic Evaluation Services).

b. Working with other state agencies to actively coordinate mental health care, particularly for individuals with dual diagnosis and children.

c. Requiring that the Contractor and each DMH Area Office collaborate to operationalize communication procedures to facilitate continuity of care between BHP services and DMH Continuing Care Services.

d. Meeting regularly with the Contractor regarding the coordination of acute mental health services, and to resolve issues encountered with regard to continuity of care, including DMH eligibility, and to plan future areas of collaboration.

e. Ensuring that regular communication occur between designated EOHHS staff and the Contractor, between EOHHS and DMH, and between DMH and the Contractor. EOHHS, DMH and the Contractor shall each establish channels of communication that ensure that each timely informs the others of all events and circumstances that materially affect service delivery or the management and administration of the Behavioral Health Program. Such channels shall also provide a forum to review and discuss data generated by the Contractor. At a minimum, such communication channels shall include monthly meetings on BHP management.

2. EOHHS Responsibilities

EOHHS is responsible for:

a. Procuring a Behavioral Health Contractor with responsibilities that include performing the DMH Specialty Programs.

b. Negotiating and executing the Contract and any amendments thereto, and ensuring that the Contract and all amendments and renewals incorporate the requirements of the DMH Specialty Programs, unless otherwise agreed to by DMH.

c. Paying the Contractor in accordance with the payment provisions of the Contract.

d. Managing and monitoring the Contractor's performance and ensuring the Contractor's satisfactory performance of the DMH Specialty Programs and other DMH-related responsibilities as specified in the Contract. This includes, but is not limited to, requiring the Contractor to:

   1) Require its Network Providers to comply with relevant Massachusetts regulations and DMH policy memorandums, including but not limited to those regulations and policies on informed consent, human rights and restraint and seclusion;

   2) Operate and provide administrative oversight of ESP Services consistent with the policies and procedures, terms and conditions set forth in Contract Section 3.4, and ensure that the ESP providers provide all ESP Services as set forth in Contract Appendix A-1, Part III;

   3) Provide benefit advocacy and coordination for Uninsured Individuals;

   4) Establish a MCPAP Unit to manage the Massachusetts Child Psychiatry Access Project and MCPAP for Moms, perform the MCPAP responsibilities set forth in Contract Section 4.5, and coordinate all MCPAP program activities with DMH;

   5) Provide a system to access Designated Forensic Professionals (DFPs) for Forensic Evaluations conducted as part of a Pre-Arraignment Protocol (PAP) as described in M.G.L. c. 123, § 18(a), and perform the Forensic Evaluation Services responsibilities set forth in Contract Section 4.6;

   6) Require its Network Providers to coordinate Covered Services for DMH Clients with DMH Case Management staff;

   7) Require its Network Providers to include DMH in treatment and discharge planning meetings for DMH Clients and homeless individuals, and ensure that their treatment recommendations are consistent with the DMH Client's service plan;

   8) Assign its staff pharmacist to participate in the DMH drug advisory committee known as the Psychopharmacology Experts Work Group;

   9) Maintain records consistent with current professional standards and all applicable state and federal laws and regulations;

   10) Submit reports to DMH pertaining to DMH Specialty Programs and other DMH-related responsibilities as specified in the Contract or as otherwise specified by DMH; and

   11) Include in its Behavioral Health Quality Management plan activities, measures and performance improvement projects that are specifically relevant to each of the DMH Specialty Programs;

   12) Participate in DMH Quality Management activities when invited, which may include but are not limited to attendance by the Contractor's Network Management staff member or designee at DMH Area quality council meetings and participation on DMH quality improvement teams, as determined necessary by the applicable DMH Area Director.

e. Requiring MBHP to enhance the capacity of the MCPAP to develop and implement strategies to increase the PCPs' capacity to identify and treat behavioral health challenges of pre-school children and their families. DMH shall transfer to EOHHS $67,422 of Race to the Top Early Learning Grant (RTTT-ELC) funds transferred to DMH through an ISA with the Department of Early Education and Care (EEC) to carry out activities described herein over the period of July 1, 2015, to Dec. 31, 2015. EOHHS will ensure that the Contract requires the MCPAP to complete the following activities to the satisfaction of EOHHS and DMH (hereinafter collectively these activities shall be referred to as Race to the Top Activities):

1) Develop and implement strategies to increase PCP capacity to identify and treat behavioral health challenges of pre-school children and their families and track encounters relating to early childhood mental health issues;

2) Develop capacity of MCPAP Hubs to provide technical assistance to the participating PPC practices and community-based behavioral health agencies regarding Triple P Positive Parenting Program.

3) Oversee and coordinate Triple P follow-up coaching for the clinicians that completed the two trainings provided in FY15.

4) Develop strategies to refer families for Triple P and report on their participation in the PCP practices and community-based behavioral health agencies where clinicians have been trained and accredited.

5) Complete evaluation report of the implementation of Triple P by the PPCs and the community-based behavioral health agencies.

6) Identify and implement strategies for increasing awareness and access to behavioral health referral resources for pre-school children and their families within all geographic regions. Establish a Race to the Top Unit that includes staffing to manage and oversee Race to the Top Activities.

7) Develop and implement additional staffing requirements to sufficiently support the Race to the Top Activities:

8) Collaborate with and coordinate all Race To the Top Activities with DMH including regularly scheduled reporting and attendance at meetings to discuss progress and challenges in implementing the Activities.

f. Requiring MBHP to fund additional ESP activities for a total FY16 cost of $1,403,388, as indicated in the full budget, **Attachment B**. The purpose of these funds is to enhance ESP safety and capacity through increased personnel and other appropriate mechanisms. In its Contract with MBHP, EOHHS will ensure that MBHP shares with DMH the results of its monitoring and evaluation activities in the monthly MBHP/DMH Programmatic Meetings that occur every month. Corrective action plans and revised or new ESP enhancement plans will be addressed in these meetings. Decisions regarding the disposition of any unspent resources associated with the DMH-funded expansion of ESP services will be made in this forum as well.

g. Requiring MBHP to use the increased FY16 state appropriation for MCPAP of $500,000 to fully staff the three regional MCPAP for Moms mental health consultation hubs to adequately meet the statewide demand for psychiatric consultation and care coordination by providers serving pregnant and postpartum women with depression and other mental health problems. As a part of this capacity building, MCPAP for Moms is also responsible for supporting new community-based postpartum depression support coalitions throughout the state.

h. Coordinating all activities with the Contractor and DMH; provided, however, that EOHHS shall ensure that DMH has direct contact with the Contractor for the purposes of allowing DMH to carry out its responsibilities (joint and separate).

i. All federal reporting and activities involving federal financial participation.

3. DMH Responsibilities

DMH is responsible for:

a. Obtaining input from DMH Area Directors, boards and other community advisory groups regarding proposed and existing Network Providers, and for conveying this input to EOHHS and the Contractor for consideration by all in approving and managing Network Providers.

b. Providing EOHHS with eligibility criteria, applicable clinical assessment criteria, and clinical protocols for DMH Continuing Care Services.

c. Transferring funds to EOHHS for EOHHS to pay the Contractor for the performance of its responsibilities as specified this ISA and described in detail in the Contract.

D. Payment Provisions

DMH shall provide funds to EOHHS as set forth in **Section 2.C.2** above, and in **Attachment B**.

3. [REQUIRED] Identify schedule of performance or completion dates or other benchmarks for performance, or as amended:

Payments and reports shall be made as required by Sections 2.D and 7 and services shall be provided as set forth in Section 2.C.

4. [REQUIRED] Justification that use of ISA is best value vs. contract with outside vendor:

   This ISA facilitates the provision of the described services through the EOHHS behavioral health vendor. See ISA **Section 6**, below.

5. Will Seller/Child department state employees (AA Object Class) be fully or partially funded under this ISA? X No Yes. If Yes, justify necessity to use state employees for the ISA vs. use of contractors (contract employees or outside vendors). N/A

6. Subcontractors. Since it is presumed that contracting through the Seller/Child is more cost effective and a better value than the Buyer/Parent directly contracting with an outside contractor(s), any subcontract entered into by the Seller/Child for the purposes of fulfilling the obligations under an ISA must be approved by the Buyer/Parent in advance of the ISA and justified as part of the ISA Attachment A, as follows: (enter "N/A" if subcontractors will not be funded with ISA funds)

   These services can most efficiently and effectively be provided through MBHP which is the Behavioral Health vendor under contract with EOHHS to provide Behavioral Health Services to MassHealth members. The Contract, entitled "The Massachusetts PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Program," was entered into on September 30, 2012, and is amended from time to time.

7. Identify any equipment that will be leased or purchased by the Seller/Child using ISA funds: (The Buyer/Parent shall determine ownership of equipment purchased by the Seller/Child with ISA funds. Enter "N/A" if equipment not included in ISA.)

   N/A

8. [REQUIRED] Identify the format and timing of ISA reports to the Buyer/Parent Department. Include the type of reports (e.g., progress or status, data, etc.), timing of reports (e.g., weekly, monthly, final) and the medium for submission of reports (e.g., e-mail, Excel spreadsheet, paper, telephone):

   EOHHS shall provide DMH with the following documents and data a timely manner in the format agreed upon by the parties:

   1. Copies of the Contract, Contract amendments, Contract renewals, Contract evaluations, and corrective actions upon execution. EOHHS shall also provide copies of any notice of termination or non-renewal of the Contract;
   2. Copies of all reports EOHHS has developed regarding acute mental health services;
   3. Such ad hoc reports regarding services the Contractor provides as described in the Contract as DMH determines it needs in its role as the state's mental health authority; and
   4. The results of any BHP consumer satisfaction surveys that may be conducted.

   The Contractor shall submit reports to DMH pertaining to DMH Specialty Programs and other DMH-related Contractor responsibilities, as specified in the Contract or as otherwise specified by DMH.

   For MCPAP for Moms, EOHHS agrees to ensure that MBHP will provide quarterly reports to EOHHS and DMH 20 days after the closing of each quarter describing program accomplishments in the following areas:

   - Operations of MCPAP for Moms regional hub teams including enumeration and description of provider encounters.
   - Implementation of provider trainings using the provider toolkit (i.e., number of trainings conducted, number of providers trained, etc.)
   - Dissemination of information on perinatal mental health community resources including support groups, mental health care, and other resources to support the wellness and mental health of pregnant and postpartum women
   - Provider enrollment with MCPAP for Moms hubs
   - Evaluation of program implementation including results from encounter forms and other tools that assess the process and outcomes of implementing the MCPAP for Moms expansion

INTERDEPARTMENTAL SERVICE AGREEMENT (ISA) FORM

For the Race to the Top Early Learning Grant (RTT-ELC) described in ISA **Section 2.C.2.f**, above, DMH will be responsible for developing the programmatic and fiscal reporting specifications for Race to the Top activities. MBHP will be responsible for generating and submitting these reports on a quarterly basis to DMH the following:

- Programmatic: PCP survey results, implementation of Triple P trainings and follow up coaching to practices and behavioral health agencies, types of technical assistance provided by MCPAP to PCPs relating to early childhood mental, and number of families participating in Triple P program; and
- Fiscal: funds spent by quarter and by grant activity.

In addition regarding the Race to the Top Learning Grant, EOHHS agrees that MBHP will provide EEC with monthly reports summarizing the guidance and oversight provided to the PCPs and the community-based behavioral agencies participating in Triple P, using a template developed by DMH in consultation with EEC.

9. Additional ISA Terms: [Insert Terms here. Do not refer to separate attachment(s)]

A. Regulatory Compliance

All activities of the Contractor, EOHHS and DMH, and any activities or services of subcontracts that may be entered into as a result of this ISA shall meet all applicable state and federal reporting and participation requirements.

B. ISA Disputes

Disputes over scope of authority and policy and management decisions regarding the ISA shall be addressed and resolved by the respective Commissioners.

C. BHP Contract Negotiations/Termination

EOHHS shall consult with DMH during any Contract negotiations (including amendments and renewals) related to the provision of services to DMH Clients and DMH Specialty Services. EOHHS shall notify DMH prior to the renewal, amendment or termination of the Contract. Unless otherwise agreed to by DMH, EOHHS shall not terminate the Contract without giving DMH at a minimum the same written notice it is required to give the Contractor.

D. EOHHS Plans for Financing If Changes in Legislation Occur

If there are any material changes to federal Medicaid or financing laws, EOHHS may, after consultation with DMH and EOHHS, change the Contract relative to pursuing Medicaid eligibility and Medicaid billings. EOHHS shall also prepare a plan for submission to and review by DMH outlining the implication of these changes for BHP financing and for the financing of DMH Continuing Care Services by DMH.

E. Amendment

The parties may agree from time to time to modify certain of the ISA's terms.

F. ISA Termination

Either party may terminate this Agreement upon 30 days' written notice to the other party.

G. ISA Officers

EOHHS designates _ Emily Sherwood ____ who shall be authorized to manage this ISA on behalf of EOHHS. Any change in this designation shall be reported to DMH in writing.

DMH designates __Jim Bergstrom_____ who shall be authorized to manage this ISA on behalf of DMH. Any change in this designation shall be reported to EOHHS in writing.

INTERDEPARTMENTAL SERVICE AGREEMENT (ISA) FORM

ATTACHMENT B - BUDGET

Check one: ____ Initial ISA Budget

__X__ ISA Budget/Account Amendment. Maximum Obligation of ISA before this Amendment: $431,104,253.60

PRIOR MMARS DOCUMENT ID: ISADMHJOINTESPEHS15B (for reference - if applicable)

CURRENT DOC ID: **ISADMHJOINTESPEHS16A**

[See Instructions for Additional Guidance on completion. Insert as many additional lines as necessary.]

A	B	C	D	E	F	G	H	I
Budget Fiscal Year	**Seller/Child Account**	**Object Class**	**Description**	**Initial ISA Amount / or Amount Prior to Amendment**	**Indicate Add or Reduce +/-**	**Amendment Amount**	**Enter "YES" if Amount is a prior FY budget reduction or a current FY "Carry-in" authorization for Federal ISA Funds**	**New Amount After Amendment**
2016	5047-0001	RR	ESP Service	$ 6,700,000.00				
2016	5047-0001	RR	ESP Expansion	$ 1,403,388.00				
2016	5047-0001	RR	Administration of DMH Specialty Programs	$ 609,000.00				
2016	5047-0001	RR	Forensic Evaluation (known as 18(a))	$ 210,000.00				
2016	5042-5000	RR	Psychiatric Access	$ 3,100,000.00	+	$500,000		$3,600,000
2016	3000-2010	RR	Develop and implement strategies to treat preschool behavioral health challenges	$ 67,422.00				
			TOTAL	**$12,089,810.00**				$12,589,810.00

FISCAL YEAR SUBTOTALS AND TOTAL MAXIMUM OBLIGATION FOR DURATION OF ISA	
FISCAL YEAR: 1998-2013 SUBTOTAL (*or New Subtotal if Fiscal Year Subtotal being amended*	$ 386,722,272.60
FISCAL YEAR: 2014 SUBTOTAL (*or New Subtotal if Fiscal Year Subtotal being amended*	$ 21,808,413.00
FISCAL YEAR: 2015 SUBTOTAL (*or New Subtotal if Fiscal Year Subtotal being amended*	$ 22,573,568.00
FISCAL YEAR: 2016 SUBTOTAL (*or New Subtotal if Fiscal Year Subtotal being amended*	$ 12,589,810.00
TOTAL MAXIMUM OBGLIGATON FOR DURATION OF ISA (*or New Total Maximum Obligation if amended*)	**$ 443,694,063.60**

INTERDEPARTMENTAL SERVICE AGREEMENT (ISA) FORM

ATTACHMENT C – FEDERAL GRANT SELLER/CHILD ACCOUNT

[Complete ONLY if Buyer/Parent Account is a Federal Grant Account. Seller/Child Department must signoff in order to process document.]

____ NEW ISA _X__ ISA AMENDMENT	BUDGET FISCAL YEAR: 2015
BUYER/PARENT DEPARTMENT: DMH	SELLER/CHILD DEPARTMENT: EHS
CTR ONLY - REVENUE BUREAU WILL ASSIGN	
Revenue Budget	Revenue Source
BUYER/PARENT DEPARTMENT MUST COMPLETE ALL ITEMS BELOW	
CENTRAL BUDGET STRUCTURE (BGCN - BQ89)	
Appropriation Number: 3000-2010	Payroll Indicator : __x__Yes ___No
Budgetary Estimated Receipts $67.422.00	BGCN Document Identification No.: ISADMHJOINTESPEHS16A
COST ACCOUNTING STRUCTURE (BGRG- BQ88)	
Total Maximum Obligation of ISA: $67.422.00	BGRG Document Identification No.: ISADMHJOINTESPEHS16A
MAJOR PROGRAM TABLE SET-UP	
Major Program (6 chars. or less): RTTELC	Major Program Short Name (same as appropriation number): 30002010
Major Program Name:	
PROGRAM PERIOD TABLE SET-UP OR EXTENDED PROGRAM PERIOD	
Effective From Date: 7/1/15	Effective To Date: 12/31/15
Program Period:	
Program Period Name:	Program Period Short Name:
PROGRAM TABLE SET-UP	
Effective From Date:	Effective To Date:
Program Name:	Program Short Name:
Program Code: **(MUST START WITH "F" followed by up to 9 characters)** **FFY12RTTEL**	Sub Account: S412A120017

FUNDING PROFILE - FUNDING LINE		
Draw Name:	Customer ID	Payment System Code – **Check one option only**
EDCAPS:	VC7000000001	**X D**
ECHO:	VC7000000002	**E**
LOCES:	VC7000000003	**L**
SMARTLINK:	VC7000000004	**S**
ASAP- OTHER:	VC7000000005	**Y**
ASAP:	VC7000000006	**Z**
GRANT- NON DRAW:	VC7000000007	**No Code**

FUNDING IDENTIFICATION	
Federal Catalog Agency: (2 digit code) **84**	Federal Catalog Suffix: (3 digit code) **412**
Letter of Credit No.: 086194854	

Authorized Signatory Seller/Child Department: _____ Date:_____ Name:

Summary of Bids Received

On July 6, 2015, the Massachusetts Behavioral Health Partnership ("MBHP") published a Request for Responses ("RFR") on behalf of MassHealth to solicit bids to provide ESP services for the Southeast catchment areas of the state, including the Brockton, Cape Cod and the Islands, Fall River, and Taunton/Attleboro Service Areas. MBHP developed the RFR in compliance with the Commonwealth's Privatization Law codified in M.G.L. c. 7 §§ 52,53, 54 and 55, as these services are currently provided by employees of the Commonwealth of Massachusetts within the Department of Mental Health.

In response to the RFR, five potential providers submitted a total of twelve bids for review within the following catchment areas:

- Brockton: 4 bids;
- Cape Cod and the Islands: 2 bids;
- Fall River: 3 bids and;
- Taunton/Attleboro: 4 bids.

Of this total, eight (8) responses were deemed to meet the minimum requirements for review as outlined in Section VII.A of the RFR.

An MBHP evaluation committee applied the assessment criteria outlined in the RFR and used the scoring rubric (included in this packet as "Emergency Services Program (ESP) Proposed Scoring Guide. September 2015) in order to evaluate each of the eight bid proposals that met minimum requirements. Based on the committee's evaluation, MBHP has selected the following two organizations to provide ESP services in the Southeast region of the state:

- Community Counseling of Bristol County (CCBC) for the Brockton and Taunton/Attleboro catchment areas
- Boston Medical Center (BMC) for the Fall River and Cape Cod and the Islands catchment areas

The following pages outlines the selected applications for the four catchment areas.

Massachusetts Behavioral Health Partnership (MBHP)
Emergency Services Program (ESP) RFR

Organization name: Boston Medical Center

Proposed catchment area name:

☑ Cape and Islands

Contact person: Joanna Buczek, MD **Title:** Vice Chair, Psychiatry
Mailing address: 85 East Newton Street, Suite 802
Boston, MA 02118
Telephone number: 617-414-4708 **Fax number:** 617-414-1975
E-mail address: Joanna.Buczek@bmc.org

Proposed subcontractor(s), if any:
Organization name: Bay Cove Human Services
Contact person: Nancy Mahan **Title:** Senior Vice President, Program Services
Mailing address: 66 Canal Street
Boston, MA 02114

Telephone number: 617-371-3004 **Fax number:** 617-371-3100
E-mail address: nmahan@baycove.org

Organization name: Vinfen
Contact person: Bruce L. Bird, MD **Title:** President and CEO
Mailing address: 950 Cambridge Street
Cambridge, MA 02141

Telephone number: 617-441-1800 **Fax number:** 617-441-1858
E-mail address: birdb@vinfen.org

Service component(s) for which the bidder proposes to subcontract to the above:

Boston Medical Center is providing the following services in collaboration with Bay Cove Human Services and Vinfen:

☑ Child Mobile Crisis Intervention
☑ Adult Mobile Crisis Intervention
☑ Community-based location
☑ Adult Community Crisis Stabilization (CCS)
_ Other: (specify) _____

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September 11, 2015

Shelley Baer, M.S.
Director of Emergency Services
Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118-5002

Dear Ms. Baer:

The Boston Medical Center (BMC) Department of Psychiatry is pleased to submit this proposal for the Emergency Services Program (ESP) Contract for the Cape Cod and the Islands Area. Key partners (sub-contractors) in this bid include Vinfen (V) and Bay Cove Human Services (BCHS), two premier community agencies who have successfully partnered with BMC in the Southeast and MetroBoston communities to provide emergency service programs and recovery services. These agencies have extensive knowledge and experience in delivering high quality, community-based and recovery-oriented crisis assessment, treatment intervention and stabilization services.

BMC proposes to lead a partnership for revitalization of the Cape Cod and the Islands Emergency Service Program in which BMC, in conjunction with BCHS, will provide mobile crisis intervention services and urgent care, and BMC, in conjunction with V, will provide community crisis stabilization services for these communities. BCHS will also provide technical support in connection with the electronic medical record that will be used by the Cape Cod and the Islands ESP.

BMC will provide seasoned clinical leadership, comprehensive program administration, and BEST program technology to assure a revitalized and robust Cape Cod and the Islands Emergency Service Program (CCI ESP). The medical and clinical infrastructure of the proposed CCI ESP is designed to assure that BMC psychiatry has direct involvement in all of the services and a substantive knowledge and oversight of the clinical work overall.

These partners have more than 100 years of experience and considerable competencies in the treatment of complex mental health and substance abuse conditions to meet the needs of culturally diverse children, families, adults, allied providers and community stakeholders. Our proposed model incorporates not only the best practice features of a comprehensive emergency services program as referenced above, but also important philosophical, policy and program practices designed to assure that the CCI ESP is focused first and last on the individuals who need our care in psychiatric and social emergencies. These include:

- A CCI ESP culture founded on recovery, embracing inclusion rather than extrusion, and diversion, with a robust family partner and consumer provider involvement in the design, oversight and delivery of ESP services;

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- Alliances with key providers, consumers, families and state agency stakeholders, designed to make navigation across the system, even in crisis, a seamless experience;
- Immediate access to clinical, medical and social information about clients to guide differential diagnosis and intervention choices. This also serves to strengthen what may be frayed linkages to caregivers and/or programs to address treatment adherence and assure continuity of appropriate care;
- Discrete services tailored to the distinct needs of children and youth, and to the family and community contexts in which they live, informed by *Systems of Care* (SOC) philosophy and practices;
- Services are organized to respond to members of the diverse racial, ethnic, and linguistic communities that comprise the Cape Cod and the Islands communities, recognizing both the risk of disparities in access to effective care for racial, ethnic, linguistic and cultural minorities, and the significance of culture to the effective treatment of mental health and substance abuse conditions;
- Stakeholder input, as demonstrated by engagement of the Southeast Recovery Learning Community, NAMI MA, JRI, ARC of Bristol County, Gateways and Martha's Vineyard Community Services in the preparation of the proposal; and
- Intersystem planning, addressing the complex social, medical and behavioral health needs of our target client population, which are typically met through a diverse, and sometimes not well integrated, array of services in the community.

BMC and its partners are excited by the prospect of putting together our longstanding commitment to high performing emergency services, our clinical and administrative competencies, and the assets of our partners to provide residents of the Cape Cod and the Islands area with a revitalized ESP. We have also submitted proposals for the Taunton/Attleboro, Fall River and Brockton ESPs. We believe that BMC, in conjunction with BCHS and V, have the capacity and expertise to undertake this considerable effort. We also believe that serving multiple catchment areas would provide opportunities for the programs to benefit from economies of scale, in sharing resources (especially during periods of high demand), from standardization of communications and practices and in enhancing access and continuity of care.

Thank you for the opportunity to reply to the solicitation and please do not hesitate to call on us for any questions you may have.

Sincerely,

Joanna Buczek, MD
Interim Boston University School of Medicine Chair
Boston Medical Center Chief of Psychiatry

Acronym Keys

ACO-Accountable Care Organizations
ALP-Alternative Lock-Up Program
ASL-American Sign Language
B-Brockton
BAMSI-Brockton Area Multi-Services, Inc.
BC-Bay Cove Human Services
BCBA-Board Certified Behavior Analyst
B-ESP-Brockton Emergency Service Program
BEST-Boston Emergency Service Team
BHS-Behavioral Health Services
BMC- Boston Medical Center
BMC-ESP-Boston Medical Center Emergency Service Program
BRC-Boston Resource Center
CARF-Commission on Accreditation of Rehabilitation Facilities
CBFS-Community Based Flexible Supports
CBHI-Children's Behavioral Health Initiative
CBL-Community Based Location
CCI-Cape Cod & Islands
CCI-ESP-Cape Cod & the Islands Emergency Service Program
CCS-Community Crisis Stabilization
CFT-Child Focused Team
CORD-Cape Cod Organization for Rights of the Disabled
CPRP- Certification for Psychiatric Rehabilitation
CPS-Certified Peer Specialist
CSA-Community Service Agency
CS-ESP-Cambridge Somerville Emergency Service Program
DBSA-Depression Bipolar Support Alliance
DCF-Department of Children & Families
DDS-Department of Developmental Services
DET-Department of Employment & Training
DMH-Department of Mental Health
DoP- Department of Psychiatry
DPH-Department of Public Health
DYS-Department of Youth Services
EATS-Enhanced Addiction Treatment Service
ED-Emergency Department
EMR-Electronic Medical Record
ESP-Emergency Service Program
FR-Fall River
FR-ESP-Fall River Emergency Service Program
FTE-Full Time Employees
ICC-Intensive Care Coordinator
IHBT-Intensive Home-Based Treatment
IHT-In-Home Therapy

IOP-Intensive Outpatient Programs
JRI-Justice Resource Institute
MBRLC-Metro Boston Recovery Learning Community
MCI-Mobile Crisis Intervention
MOR-Milestones of Recovery

MOU-Memorandum of Understanding
NAMI-National Alliance on Mental Illness
PACT-Program for Assertive Community Treatment
PES-Psychiatric Emergency Services
PHP-Partial Hospitalization Program
PI-Performance Improvement
PPAL-Parent Professional Advocacy League
PR-Psychiatric Rehabilitation
PSP-Parent Support Program
QA-Quality Assurance
QI-Quality Improvement
QM-Quality Management
QOLO-Quality of Life Outcomes
RAP-Runaway Assistance Program
RCC-Recovery Connection Centers
RFR-Request for Response
RLC-Recovery Learning Community
SERLC- Southeast Recovery Learning Community
SOAP-Structured Outpatient Addictions Programs
SOC-Systems of Care
STARR-Stabilization, Assessment, and Rapid Reintegration
TA-Taunton Attleboro
TA-ESP-Taunton Attleboro Emergency Service Program
TIP-Transition to Independence Project
TPP-Tenancy Preservation Project
UCC-Urgent Care Center
V-Vinfen
VNA-Visiting Nurse Association
WRAP-Wellness Recovery Action Plan

Narrative Response

1. General Qualifications and Infrastructure

The Boston Medical Center (**BMC**) Department of Psychiatry (DoP) is the bidder for the Emergency Service Program (ESP) Contract for Cape Cod and the Islands (CCI). Key partners (sub-contractors) in this bid include Bay Cove Human Services (**BC**), and Vinfen (**V**).

BMC will lead the partnership providing seasoned clinical leadership, comprehensive program administration, and Boston Emergency Service Team (BEST) program technology to assure revitalization of the **Cape Cod and the Islands Emergency Service Program (CCI-ESP)**. BMC's partners, BC and V, have considerable experience in collaborating with allied providers and community stakeholders, and expertise in providing evidence-based Psychiatric Emergency Services (PES) for the treatment of complex mental health and substance abuse conditions among culturally diverse children, families, and adults.

BMC, in conjunction with BC and V, will provide urgent care, crisis stabilization, clinical triage, Mobile Crisis Intervention (MCI) and psychiatry services. BC's subcontract also includes technical support in connection with the Electronic Medical Record (EMR) that will be used by the CCI-ESP.

BMC, BC, and V have longstanding track records of building care partnerships to benefit clients. BMC will leverage its competence in building and maintaining the robust, successful BEST and Cambridge Somerville Emergency Services Program (CS-ESP). Productive alliances with consumers, their families, state agencies, local governments, criminal justice organizations, national and local community and social service agencies, religious and cultural organizations, and behavioral, healthcare, and substance abuse providers are a requisite for an effective, integrated, and seamless experience for clients. To that end, BMC is partnering with BC and V – two major providers with clinical expertise and a breadth of experience in developing community programs and collaborations.

1.1 Licensure

1.1.1 ***Department of Public Health (DPH)-Licensed Outpatient Mental Health Clinic***: **BMC/BC/V**: Yes/Yes/Yes

1.1.2 Licensed as a Hospital

1.1.2.1 DPH: Yes/No/No 1.1.2.2 Department of Mental Health (DMH): No/No/No

1.2 Accreditation

1.2.1 National Organization: Yes/Yes/Yes

1.2.2 Joint Commission/Commission on Accreditation of Rehabilitation Facilities (CARF) /CARF

1.3 Currently Contracted MassHealth Provider/Applicant Yes/Yes/Yes

1.4 Three Years of Experience Providing Behavioral Health Services (BHS) to Wide Range of Populations Yes/Yes/Yes

1.4.1 # Years Providing Behavioral Health Services to Children, Adolescents, and Families: 31+/12/20

1.4.1.1 # Youth Served CY14: BMC: 9,944 encounters for clinic and ESP combined; BC: 2,169 BEST, 1,113 Early Inter., 300 Family Support Center, 100 Parent Support Program; V: 300

1.4.2 # Years Providing Behavioral Health Services to Adults: 31/42/38

1.4.2.1 # Adults Served in CY14: BMC: 53,134 encounters for clinic and ESP combined; BC: 1,990; V: 100 programs and 6263 people served; 238 young adults and adults Cape Cod Community Crisis Stabilization (CCS); 2,792 adults Community Based Flexible Supports (CBFS); 166 Program for Assertive Community Treatment (PACT); 279 homeless services; 1,575 Clubhouse; 108 Recovery Learning Centers; 929 Clinical/Outpatient services.

1.4.3 Behavioral Health Services Provided and Populations Served: BMC provides BHS to children and adults, including emergency psychiatric services, outpatient BHS, consultation and liaison services, peer support and recovery services, refugee mental health services, and disaster mental health counseling services. BMC has: been the lead agency in BEST for the past 12 years; participated in the BEST Program as a Designated Emergency Department (ED) since 1995; and been the lead agency for the CS-ESP for six years. BMC's DoP is organized to respond to a racially, ethnically, and linguistically diverse, urban population who faces complex addictions and an array of psychiatric and health conditions.

BC operates eight CBFS teams; a specialized outreach team; a Housing First program (Home At Last); three Clubhouse programs; PACT; Day Treatment; Tenancy Preservation Project (TPP); two specialized residences providing treatment for 12 men with mental illness and problematic sexual behaviors and a former Quarterway residence; 40 community residences with partial and 24-hour care; a Mental Health Clinic, providing psychopharmacology and therapy; a DMH transitional shelter, and four CCS programs. BC has long operated specialty residential and clubhouse programs serving Spanish, Vietnamese, Cantonese, and Mandarin speaking adults. Two bi-lingual BC CBFS who represent these cultures work with these populations. BC is a BEST partner, providing crisis services to both youth and families in the Boston area, while all other services are available to adults only.

V provides community based services to people with psychiatric conditions, intellectual and developmental disabilities, brain injuries, and behavioral health challenges. V's Psychiatric Rehabilitation (PR) Division is dedicated to the recovery of adults and transitional age youth living with psychiatric disabilities, substance addiction, and/or HIV/AIDs throughout eastern Massachusetts. V's outreach-oriented assertive community treatment serves clients via CBFS Services and PACT. V has removed cultural and linguistic barriers to service by recruiting a diverse staff, accessing translators as necessary, respecting and celebrating cultural differences and linking clients to culturally relevant community supports.

1.5 Presence in and Knowledge of the Catchment Area

1.5.1 Current Location: BMC, BC, and V plan to utilize and expand the current CCI CCS Program location in Hyannis to establish a Community Based Location (CBL) which co-locates the CCS, urgent care and crisis intervention services.

1.5.1.1 # of Years Operated in Uninterrupted Physical Location in Catchment Area: V has served DMH clients and the homeless population in the CCI site since the late 1980's – more than 35 years – by providing Crisis Services, Community Rehabilitation and Support (CRS), Homeless Outreach, Supported Housing, Host Family and PACT services. V currently operates the CCI CCS Program located in Hyannis, MA. This program provides between six to seven CCS beds and three to four DMH respite beds at any given time. V's Homeless Outreach Team services up to a total of 279 clients per year. Since 2007, the V CCI PACT program has served up to 80 clients a month and has operated one of the CCI CBFS Programs for 90 DMH clients since 7/2009. BMC, in conjunction with V, currently operates the CCI Recovery Learning Community (RLC) programs. The main program site, the Hyannis Resource Connection Center, is located at 45 Plant Road, Hyannis, established in 2012.

1.5.1.2 Address of above with Longest Duration: The CCI PACT, Homeless Services, and CBFS Team are all located at 1019 Iyannough Road in Hyannis, MA. The programs occupy various units within this office park. The CCI CCS Program is located at 270 Communication Way Building, #1, Hyannis, MA.

1.5.1.3 Rationale for and Plan to Establish a Physical Location: We will use the current location listed above to collocate the CBL and CCS.

1.5.2 Brief Needs Assessment: Many of the CCI-ESP communities have significant community health and mental health services that we will support and access in our efforts to provide emergency services such as but not limited to: Homeless Prevention Council of Lower Cape Cod, Outer Cape Health Services, Harvard Health Medical Center, Duffy Health Center, Able Nursing/Visiting Nurses Association (VNA) Services, Veterans Administration, Elder Services of Cape Cod, Family Continuity Outpatient Services, SouthBay Mental Health- Outpatient Services, and the Wampanoag Tribe Health Care Resources. Martha's Vineyard Community Services, a one stop shopping for most of the mental health and community services for the island including crisis services, outpatient offices, substance abuse counseling (individual and groups), outpatient psychiatry, island-wide youth collaborative, and Head Start, among other critical services. Family and Children's Services of Nantucket is the key resource for mental health and substance abuse services in Nantucket. It will be particularly important to develop strong working relationships with key agencies on Nantucket and Martha's Vineyard to ensure continuity of services to these island communities,

The current CCI-ESP provides many quality services, yet concerning limitations and gaps need to be effectively addressed in order to ensure that consumers in crisis are responded to in a timely, respectful, and meaningful manner. Historically, the crisis services in many of the CCI communities have been designed to be reactive to acute psychiatric emergency issues and not focused on early intervention and prevention. Stakeholders report that the community has for years expressed the concern that the ESP team would not provide MCI services to the client's home, residential program or other human service facilities, and would only evaluate the client at the local ED. Local EDs have been overcrowded by individuals with acute psychiatric and substance abuse problems needing crisis evaluation and treatment. Consumers face long waits which may exacerbate their psychiatric issues and increase the likelihood of hospitalization.

1.5.3 Established Relationships with Stakeholders: BMC, BC, and V are committed to providing early access, upstream interventions, and accessible PES to those in need. Critical to these goals are the development of strong relationships with stakeholders. BMC, BC and V have longstanding collaborative, collegial, and respectful partnerships with key state agencies including DMH, Department of Developmental Services (DDS), Department of Children and Families (DCF), Department of Youth Services (DYS), DPH, Department of Employment and Training (DET), MA Commission for the Deaf and Hard of Hearing and MassHealth managed care organizations. BMC and V, in particular, have well-established, effective working relationships with many key CCI stakeholders. BMC works closely with the Southeast Area DMH staff in developing recovery services in the CCI. V has established, built on, and maintained strong linkages with a variety of community-based resources, including but not limited to: National Alliance on Mental Illness (NAMI); Cape Cod Healthcare; Duffy Health Center; Cape Cod & Island Community Mental Health Center; South Bay Mental Health; Community Support Associates through MASS Rehab; Cape Organization for Rights of the Disabled (CORD); and the Veterans Administration.

1.5.4 Interface with Existing Crisis Program: V currently provides ESP CCS services in the CCI area and interfaces regularly with the existing DMH ESP and with DMH partner agencies like Martha's Vineyard Community Services who provide crisis services in the CCI area. BC mobile crisis interfaces with existing mobile crisis teams via the Mobile Crisis Intervention (MCI) model.

1.6 Continuum of Care: BMC offers a continuum of complementary programs and services targeted to the unique needs of children, adults, elders and their families in concert with the continuum of BHS offered by BC and V described in section 1.4.3. See Attachment 1.

1.7 Administrative Infrastructure: The BMC DoP leadership team includes: Joanna Buczek, MD, Vice Chair of Psychiatry, BMC; Anna Fitzgerald, MD, Medical Director, PES; Joan Taglieri, MSN, Director, Clinical Operations, Psychiatry and BEST; Sarah Carignan, MBA, Administrative Director, Psychiatry; Marion Burke, MSN, Director of Quality Management (QM) and Training, Psychiatry; Andrea Hall, LICSW, Clinical Director of BEST and CS-ESP, Tasha Ferguson, LMHC, Assistant Clinical Director and MCI Director; and Cindy Gordon, LICSW, Clinical Director, PES and Adult Outpatient, Psychiatry. The team is directly involved in the administrative, clinical and financial oversight of the BEST and CS-ESP and will be responsible for the implementation of CCI-ESP in partnership with BC and V. BMC, BC and V have considerable experience and competency in behavioral health service delivery, system development/oversight, and delivery of ESPs serving youth and adults.

1.8 Medical and Clinical Infrastructure: BMC's model strives to combine its medical and clinical expertise with the critically important assets and roles of significant providers in the CCI community. The medical and clinical infrastructure of the proposed CCI-ESP is designed to assure that BMC psychiatry has direct involvement in all of the services and a substantive knowledge of the clinical work overall, coordinating the local capacity and competence to assure the integrity and continuity of care for each child or adult served. Medical and clinical oversight of CCI-ESP will be provided through an interrelated committee structure that includes four key elements.

The current ESP Senior Leadership Committee (Buczek, Fitzgerald, Burke, Carignan, Hall, Ferguson, Gordon, and Taglieri) will also serve as the **CCI-ESP Senior Leadership Committee** joined by the new CCI-ESP and MCI Directors. Consistent with the BEST/CS-ESP model, the Committee will meet weekly to manage and oversee CCI-ESP medical and clinical aspects.

The **CCI-ESP Clinical Leadership Committee** will mirror the existing BEST/CS-ESP Clinical Leadership Committee; be comprised of BMC, BC, and V medical and clinical leadership; meet weekly; oversee day-to-day operations, ensure consistency in clinical practice, and manage the system of care; manage quality, including policy and procedure development, compliance with applicable standards, regulations, and utilization review and training.

Based on the BEST and CS-ESP model, the **CCI-ESP Advisory Committee**, comprised of key stakeholders, including behavioral health and social service agencies, consumers and family members, child advocacy groups, DCF, DDS and DMH, representatives of special needs citizens and others in the catchment area, will meet quarterly to inform policy issues and practice, and monitor responsiveness and effectiveness of ESP.

The ESP Medical Leadership Committee, is comprised of the ESP Medical Director, CCS Medical Director and all the on-call child and adult Psychiatrists, who provide backup consultation for the Southeast ESP. A monthly meeting of all Psychiatric Nurse Practitioners who provide CCS services includes supervision, training, case review, and consultation.

1.9 QM Infrastructure

***1.9.1 Key Staff Positions and Infrastructure* Elements**: The **Director of QM** is responsible for the development and oversight of a fully-integrated Performance Improvement (PI)/QM plan which ensures the quality, appropriateness, and continual improvement of services provided by the BMC-ESP. S/he also provides Quality Improvement (QI) education and information to all components of BEST. Additionally, the Director identifies and creates reports that provide data

by which to measure and evaluate the ESP's compliance with performance standards - some of which have been defined by ESP leadership, and others by payers and regulatory groups.

The **Senior Leadership Committee** (see 1.8) meets weekly, functions as the executive group, and oversees the QM Program including: QI activity prioritization; PI activity initiation, oversight, coordination; report review; and approval of PI teams' recommendations. One to two of the monthly meetings also include the Medical Directors of BMC PES and partner designated EDs, the ESP Assistant Clinical Director/Youth MCI Program Director, and Urgent Care Center (UCC) Managers—the **QM Committee**.

The Clinical Leadership Committee, see 1.8 above, will serve as the **QM Committee** and: 1) establish expectations and performance standards; 2) review volume, activity, and utilization data to identify high-user clients, diversionary and hospitalization rates, barriers to accessing service, etc.; 3) identify opportunities for improvement; make QI/PI recommendations to Senior Management Team; 4) manage the PI process and ensure its implementation to measure, assess and improve performance; 5) resolve problems/complaints that could adversely affect service delivery; and 6) survey stakeholders, review results and identify target areas for improvement.

The CCI-ESP **Advisory** Committee, which will meet bi-monthly to inform QM Committee's work, will be comprised of internal and external stakeholders, e.g. the School Department, Police Department, the Parent Professional Advocacy League (PPAL), Mental Health Court Programs, consumers of mental health services, representatives of homeless shelters and services, DMH, DDS, DSS, DYS, and key community providers.

1.9.2 Current QM Plan: See Attachment 2.

1.9.3 QM Tools and Strategies: The BMC-ESP QM Program focuses on both Quality Assurance (QA) and QI. **QI** examines existing work methods, processes and systems, and develops ways to make them better. Rather than solely problem-based, QI assumes that opportunities for improvement always exist. **QA** seeks to answer the question: what do you do and how do you know you're doing it well? Therefore, each component of BEST considers: 1) the most important aspect(s) of your work, the most important things that you do, and why you are here; 2) how do you know that you're doing those things well/correctly, objective data or information that informs that conclusion; and 3) how those data are collected, how often the data is examined, performance standard (percentage or numeric) set for your service. In addition to each component of the service creating indicators of quality, BEST identifies aspects of its work which are high risk, high volume, or problematic. QA and QI activities and teams may be organized to address these issues; they may be also be referred to existing committees for exploration and problem solving.

1.9.4 Data and Information Use: BMC ESP created a web-based EMR into which all encounters are entered and with 40 standing data reports that pull information from client records and encounters. All users can easily see information for any time period and special reports can be requested and quickly generated. Clinicians and Managers can access information and track various aspects of their performance on a weekly and monthly basis. Reports include volume flow by time of day and week, allowing appropriate allocation of resources to meet the changing demand. ESP leadership teams regularly review reports in order to track the program's compliance with performance standards and inform development and improvement decision-making. A detailed description of how various data are used is found in Attachment 2.

2. ESP Core Competencies

2.1 Crisis Services

2.1.1 Experience: The contractor and sub-contractors have extensive track records and staff members with long tenure and experience in providing crisis services:

- For more than 12 years, BMC has held the contract with MBHP for BEST and has been a sub-contracted designated ED for BEST since 1995. BMC has held the contract with MBHP for CS-ESP for more than six years;
- BC has been a BEST sub-contractor for more than 12 years, providing mobile services to Boston's largest, central neighborhoods;
- V operated a crisis unit under BEST prior to 2004 and currently operates one for CCI-ESP.

2.1.2 Success

2.1.2.1 Response Time: BMC has focused on response time as a quality measure with its current ESPs. Please see Attachment 3 for more detailed information.

2.1.2.2 Variable Demand: Please see Attachment 3 for more detailed information.

2.1.2.3 Staff: BMC has had great success attracting leaders and clinicians with many years of direct experience working as crisis clinicians, as well as in providing mental health services to all ages in a variety of community settings. Please see Attachment 3 for more detailed information.

2.2 Mobile Services

2.2.1 Experience: Under current BMC ESP contracts, clinicians have made 33,291 initial evaluation visits to community sites, *excluding hospitals, ESP UCCs and CBLs,* since 2003. Community sites include homes, DMH and DDS group homes, DYS facilities, DCF residential programs, nursing homes, shelters, detox programs, schools, police stations, court clinics, Logan Airport, subway stations, on the street, in primary care/clinic offices, elder service agencies, and in community centers (e.g., boys and girls clubs). For the year ending May 15, 2015, the BEST BC team performed 61.45% of youth and 57.20% of adult evaluations outside of EDs. The number of evaluations in the community was 3,118, excluding follow-up visits. All populations who call the 800# are served by Mobile Teams, unless there are considerations of dangerousness or imminent risk for self-harm or harm to others; in these cases, BEST facilitates safe transport to a designated ED for evaluation and containment. Home visits are conducted 24/7 for youth and adults on a case-by-case basis, exceeding MBHP ESP performance specifications. Partner agencies BC and V have decades of experience providing community-based services involving outreach and comfort in meeting clients outside of formal settings.

2.2.2 Implementing Strategies to Create a Revitalized Culture: The ESP triage and Mobile Clinicians are clear from the time of orientation that the mission is to respond to persons where they are evidencing need or distress. Evaluations in the person's home (or other familiar setting) provide the richest picture of the person's whole self, the context of the crisis (what's happening in his/her environment), and other variables that may help or hinder access to care. Because of the value placed on such practice, staff report high satisfaction with the quality of the service they provide on behalf of youth and adults. In 2015, BC Mobile Clinicians completed 987 initial encounters at *private* homes, not including follow-up visits. Staff are trained to understand that people can suffer iatrogenic illness when using 911 ambulances and high stress EDs. People brought into EDs by Section 12 report feelings of coercion, especially when Section 12 may not have been indicated. A frail elder seen in the ED can look far more functional and capable of caring for oneself than during a home visit involving direct observation of self-care, availability of provisions, and general safety of the environment.

These themes are stressed both in training staff and in making community presentations to stakeholders about the value of community-based interventions. Other topics include how the community site offers the opportunity to join with the individual and his or her collaterals and the economies, in time and dollars, achieved outside the ED venue. Relationships with Accountable Care Organizations (ACOs) will stress the common goal of providing coordinated intervention "upstream" in the arc of a crisis, reducing reliance on high-cost EDs.

2.2.3 Overcoming Challenges to Creating a Revitalized Culture: In CCI-ESP, we anticipate using our integrated BMC/BC partnership to build a well-resourced Mobile Team with the experience and competencies to win the confidence and trust of stakeholders. The biggest challenge is carrying the message about mobile crisis to potential users and referral sources. Based upon preliminary conversations with agencies and vendors, mobile and CBL evaluations are viewed as a positive alternative to hospital settings and welcomed in many instances.

A challenge in the CCI area will be introducing clients to a new site, given that the DMH site presently used for CBL will not be available for the next ESP provider. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients who present at the Cape Cod & Islands Mental Health Center (Pocasset MHC) in crisis are triaged with the ESP and not referred to an ED.

Outreach efforts to community entities will include: presentations/discussion on process and goals of MCIs (See Attachment 4 for a training tool BEST currently uses); setting realistic expectations of what mobile interventions can achieve; and establishing a feedback loop for entities to share experiences with ESP leadership for QI.

2.2.4 Experience with Community Behavioral Health System for Youth and Families: Since 2009, BMC and sub-contractor BC have been committed to the delivery of MCI services utilizing the Ten Principles of the Wrap-Around Process as a guiding philosophy shared by the other Children's Behavioral Health Initiative (CBHI) services. A high priority is placed on providing MCI services in the least-restrictive community setting, and on collaborating closely with the family's providers and supports of choice. Outreach to share information on MCI and to encourage collaborative, early intervention is regularly and routinely made to community entities. Problems and barriers are identified and addressed through initiating system-wide dialogue and planning. The goal of such efforts is to assist in stabilizing and supporting youth to be maintained in the community in conjunction with their existing behavioral health providers and natural supports.

2.3 Diversion

2.3.1 ED Diversion

2.3.1.1 Experience and Strategies: From July 2003 to Dec. 2008, in a catchment area with nine major hospitals with EDs, BMC's BEST performed just under 14,000 (2,545 annually) adult and child community evaluations, or 28% of its total encounters. From Jan. 2009 to June 2015, that number grew to 33,181 (5,105 annually) initial community evaluations, or 31.2% of total encounters. Volume includes providing commercial evaluations in a busy ED; therefore, MBHP data for public payers would show a higher percentage of community evaluations.

In CCI-ESP the percentage of community evaluations for youth indicates the DMH MCI team has had success in providing mobile intervention for the MCI population. BC has demonstrated ability to exceed the standard of 60% MCI intervention in the community would maintain and hopefully improve this measure in the subject catchment area. In addition, BEST as a whole currently sees 27% of all adults in the community. Despite the large number of hospitals BEST serves, its rate for adult community evaluations is better than the current CCI DMH team has

achieved. A challenge in the CCI-ESP will be introducing clients to a new site, given that the DMH site presently used for CBL will not be available. Success in seeing clients in the community will depend on effective collaboration with DMH to ensure clients who present at Pocasset MHC in crisis are triaged with the ESP and not referred to an ED.

Strategies employed to date by BMC and BC include: 1) 800# Call Center master's level Clinicians assessing every case for opportunity to conduct the evaluation in the community; only those cases in which acute risk to self or others is present and cases involving potentially acute medical issues are transferred to an ED; 2) BEST continues to do significant outreach to schools, behavioral health providers, primary care clinics, shelters, housing agencies, VNAs, police, and many others, promoting the value of community-based evaluations; 3) By working with the Boston Police and EMS, BEST police co-responders and BEST 800# have diverted more than 500 people from "automatic" ED visits since August 2011 by offering on-site and telephonic clinical support for first responders; many of these diversions did not require a full ESP evaluation and are therefore not reflected in BEST MBHP data reports; 4) Regular engagement in crisis and risk management planning with clients of Community Service Agency (CSA)s, DMH, DCF, DDS, DYS, and other entities; and 5) Outreach to ACOs to coordinate "upstream" interventions early in arc of crisis.

2.3.1.2 Strategies to Create Culture: The culture of diversion from EDs is already present in BMC, V and BC, and its development will continue to be nurtured. All leadership firmly believe that in the majority of cases, the best outcomes happen outside of the ED and, more specifically, that community interventions allow for better care coordination. Community-based mobile response is part of the training, orientation and annual performance reviews for staff and trainees. By educating partners, consumers and families about a wide range of community resources, encouraging early intervention, and providing timely, competent crisis response, efforts to move crisis care away from the hospital setting are reinforced. As an example of success, BMC's own ED has been able to reduce youth coming to the ED by 16% for the year ending June 30, 2015, by educating users about the mobile alternative and by "handing" interventions back to the BEST BC Mobile Team for youth who originally presented at the ED.

2.3.1.3 Strategies to Shift Away from ED: 1) Work with behavioral health and primary care provider networks to steer clients in crisis to the ESP and away from EDs. This would involve encouraging providers to routinely share information about the ESP with their clients, and in particular, to promote on their websites, in their voicemails, and in off-hours consultation the use of the ESP when in crisis; 2) Outreach to major holders of CBHI, DMH, DDS, DCF, and CBHI contracts to form alliances, create memoranda of understanding, and develop protocols for managing crisis situations that prioritize use of ESP; 3) Outreach to ACOs to develop Memorandum of Understanding (MOUs) for involving the ESP early in the trajectory of a crisis; 4) Work with EDs to identify major sources of referrals to their venues and join with ED leadership in developing alternative strategies with referral sources; 5) Further develop crisis planning and risk reviews for persons served by CSAs, DCF, DMH, DDS, and DYS; and 6) Utilize the 800# Call Center to assess every case for the opportunity to conduct the evaluation in the community.

2.3.1.4 Challenges to Create Culture: Strategies to address the following challenges are outlined in 2.3.1.1 and 2.3.1.3 above. Challenges include difficulty transforming long-held practices in a community that relies heavily upon ED resources; addressing referring professionals' personal and agency liability concerns; and lack of education regarding efficacy and benefits of community-based interventions.

2.3.2 ED-Specific Diversion Plans

2.3.2.1 Collaboration with Hospital: See Attachment 5 (including 2.3.2.1.1, 2.3.2.1.2, 2.3.2.1.3, 2.3.2.1.4, 2.3.2.1.4.1) for collaboration plans/existing agreements. Outreach has been made to Cape Cod Hospital, and efforts are continuing to collaborate with Falmouth Hospital, Nantucket Cottage Hospital, Martha's Vineyard Hospital, and Pocasset MHC.

2.3.3 Diversion from Unnecessary Psychiatric Hospitalization and Other Placement

2.3.3.1 Experience: BMC's BEST has a strong history in diverting clients from inpatient psychiatric hospitalization. For the year ending June 30, 2015, BEST overall diverted 69% of clients evaluated to other, less restrictive resources. Six of nine hospitals in BEST's current ESP area screen all psychiatric cases before contacting BEST; therefore, the cases referred to BEST represent the most acute presentations and are less likely to be diverted from hospitalization. This contributes to BEST's overall hospitalization rate being somewhat inflated. BEST BC's adult hospitalization rate is 24.33% for the year ending June 30, 2015. Despite a high acuity in the population seen, BC has kept youth inpatient hospitalization rate to 22.69%. BMC's own designated ED has kept youth hospitalization rate to 17.71% for the year ending May 31, 2015.

BEST uses urgent psychopharmacology and accelerated intakes via its partners' outpatient departments, to intervene quickly and lower the risk of out-of-home placement. BEST utilizes other community-based interventions to the extent these are accessible; the ESP's own CCS programs; structured outpatient addictions programs (SOAP), partial hospitalization program (PHP), in-home therapy (IHT), intensive home-based treatment (IHBT), and intensive outpatient programs (IOP).

2.3.3.2 Strategies to Create Culture and Educate: In the current BEST ESP, BMC has worked to promote a philosophy of recovery using community resources, holding the following principles: 1) Crisis evaluation focuses on engaging client and family in treatment; 2) Crisis evaluation is not solely triage but also treatment; 3) The best crisis work reveals and utilizes client's strengths, inspires hope, and meets the client where he or she is; 4) Hospitalization is more often treatment of last resort; 5) Hospitalization can be regressive, traumatizing, and cost inefficient; 6) Good clinical care may involve taking risks and it is the thoroughness and communication of awareness of risk that protects clients and treaters alike; and 7) Responsibility for care of self and avoidance of risk is shared by the client, provided he or she is not grossly psychotic or cognitively impaired.

Education of families and providers is important and ongoing. The following methods of working with people in crisis are stressed: offering choices; engaging concentrically for individuals who are scared or threatened; using an easy, non-direct, increasingly deeper process; seeking collateral perspectives; remaining aware of one's own frustration and inevitable potential for projective identification; and sharing and documenting risk.

2.3.3.3 Strategies and Resources to Maximize Use of Diversionary Services: These include offering high-quality, accessible CCS services within the ESP; access to urgent outpatient intakes and psychopharmacological appointments; and seamless coordination with vendors who provide the continuum of services, including the new CBHI levels of care serving youth.

2.3.3.4 Designated ED Model: BMC does not plan to use the designated ED model.

2.4 Recovery-Oriented Services:

2.4.1 Hiring Practices

2.4.1.1 Experience: BMC DoP leadership has actively promoted the principles of recovery, resilience, and strength-based treatment for many years in its behavioral health ambulatory service and in its PES. We work with Managers of all of ESP components to develop ways to

facilitate the hiring of Clinicians who share our beliefs in this area and who have experience practicing the principles of recovery and resilience. The orientation and ongoing education of staff includes a focus on recovery and strength-based treatment approach. In 2008, BMC was awarded the contract to be lead agency for the creation of the Metro Boston Recovery Learning Community (MBRLC). In 2012, BMC became the lead agency for the Southeast Recovery Learning Community (SERLC). BMC continues its active lead agency role to maintain and develop services in these RLCs, which work closely with ESP leadership and clinical staff.

The SERLC under the auspices of BMC has a network of five Recovery Connection Centers (RCC) which are located in Brockton, Taunton, Hyannis, Plymouth, and Fall River. Support groups are also run in the New Bedford community. All five centers are staffed and run entirely by peers, persons with lived mental health experience. The leadership of SERLC is comprised of five RCC Directors/Coordinators, the SERLC Director, and the SERLC Chair. The leadership team meets bi-weekly to address concerns. The SERLC will work closely with the proposed BMC Southeast ESPs as it helps publicize the program, recruit peers for employment, and connect individuals served by the ESP to the RCC and the SERLC. The Hyannis RCC, located at 45 Plant Road, is active five days per week.

It has long been the practice of BC to recruit highly trained applicants, advertising in language that is recovery oriented in nature, whose experience has been with the mental health recovery movement by way of education, internship and/or past employment. The recovery community has educated universities and job sites where recruits receive training, thereby creating an applicant pool rich in experience with a community-based treatment philosophy. The Mobile Team has recruited and hired clinical staff with lived experience for a variety of positions both in the ESPs and elsewhere in the agency. This allows for greater understanding and compassion toward the clients served.

V's dedication to helping people recover through state-of-the-art rehab services started in the late 1980s. V is person-centered and has a proven record of positive client outcomes: improved symptom management; increased self-reliance and independence; improved daily living skills and housing stability; reduced hospitalization rates; and progressive improvements in quality of life. V is a founding member of MassPRA, an advocacy organization of clients, providers and funders dedicated to promoting rehab and recovery-focused services. MassPRA's first President was a V leader; and a V leader currently serves on the Board of Directors. In 2006, it began providing fee assistance and training to enable staff to sit for their Certification for Psychiatric Rehabilitation Practitioners (CPRP) exam. Today, it has 55 CPRPs on staff.

2.4.1.2 Recruitment Strategies: BMC's academic partner, Boston University, has a master's degree program in Counseling Psychology which leads to LMHC licensing. The curriculum of this program has a strong focus on recovery. Many of these students, in the first and second year of their program, do six month-long clinical placements in BEST. BMC has hired many of the graduates of this program into positions within BEST. BEST also provides clinical placements/ internships for students from area schools of social work. These programs have successfully included principles of recovery and strength-based treatment into their curricula. During students' time with us, their knowledge and understanding of recovery is enhanced through hands-on clinical experience and staff training. Upon graduating from their programs, we can select for hire those people who we feel have truly incorporated the recovery philosophy into their practice.

BC fosters an environment where all served can recover. BC currently employs 8 full time staff members who have completed the Certified Peer Specialist (CPS) training program. These

Peers are deployed across CBFS teams and ESPs and bring tremendous value through their lived experience with severe and persistent mental illness. The Peer Specialists work one-on-one with clients, educate other team members, and help promote the organization's philosophy of hope, recovery and resilience. BC also employs Peers who facilitate groups at the Wellness Center.

The first step in V's recruitment screening includes questions that specifically assess a candidate's recovery oriented perspective. If a candidate moves on to the interview phase for a position then V Managers are trained to recruit staff with a strong foundation in PR and recovery practices. The interview process is multifaceted and includes a client interview component. This helps obtain the client's perspective, as well as observe the candidate in a similar environment in which they will be working. V provides clinical placements/internships for students from area schools of social work. It has had a similar experience as BMC as described above.

2.4.2 Integration of Peers and Family Members

2.4.2.1 Commitment to Recovery-Oriented Services: Peers are represented on a number of BMC committees, including the DoP Ambulatory Services Core Managers group, the Peer Navigator Project, and the BEST and Cambridge/Somerville ESP Advisory Committees. BMC invites MBRLC leadership and Peers to participate in key meetings and committees and to have a voice in decision-making and in program design. MBRLC leaders participate in many community, state, and national boards related to mental health and recovery movement programs. Additionally, the SERLC has agreed to work with BMC and its partners in the planning and implementation of ESP services, in the recruitment, hiring and training of Peer Specialists, and in providing trainings for ESP staff.

BC welcomes consumer and parent participation throughout all services. Consumers and parents are active participants in the BC Human Rights Committee, and the Board of Advocates.

V understands the tremendous value people with a lived experience bring to the company. Its current Director of Recovery Services has published articles and book chapters to advance this field. V's two PACT teams employ Recovery Specialists. The Cambridge/Somerville RLC employs one person in recovery and the SERLC employs 13. Each of the CBFS assertive action teams has at least one Recovery Coordinator, for a total of 20. V has 15 CPS staff employed in various programs. The Director of Recovery holds monthly peer supervision groups regionally for all staff employed in peer positions within the organization. All people in recovery who work at V are encouraged to attend monthly "Lunch and Learns" with the Director of Recovery to learn together and support each other. Peer Workers are encouraged to participate in regional or statewide groups for CPS, PACT Recovery Specialists and other focus groups and obtain CPS training as a key credential for their work.

2.4.2.2 Current and Planned Peer Engagement: Currently, the Peer Director of the MBRLC is a member of the Core Planning group for this ESP proposal, and is integral to the design of a program model that incorporates Peer Workers. For more than a year, Peers from the MBRLC have worked with clients in the BEST CCS and on DMH inpatient units in the Solomon Carter Fuller Mental Health Center, conducting support groups and providing information about recovery and treatment resources. At least annually, members of the RLC do presentations for the BMC DoP Grand Rounds series and for the all staff training sessions for staff of the BEST and CS-ESPs.

Since the inception of the recovery movement in the state of Massachusetts, it has been BC's practice to hire Peer Specialists in the ESP; and since the 2009 advent of CBHI, Family Partners. Peers and Family Partners act as consultants to the team on recovery based experience and treatment, working with Clinicians in all phases of the evaluation and follow up. Peers act as a

resource in the referral process, maintaining a database of recovery oriented resources in the greater Massachusetts area.

The numerous Peers within V's workforce provide training to their co-workers on topics related to recovery and resiliency. V has several active Family Councils throughout the CBFS programs. These Councils are in place to advise leadership as to what is going well and what isn't in services. Clients are active participants in the V Human Rights Committees. The role of the Peer Worker in the CCS will be to ensure the environment is one that promotes safety, recovery, and treatment. The CPS staff will also provide a peer-to-peer support and psycho-education about wellness and recovery.

2.4.2.2.1 Hiring and Integration Strategies: An important recruitment strategy that BMC, BC and V employ is requesting that Peer leaders in the community identify potential candidates. All post opportunities on web-based sites such as Idealist and Craigslist. Other targeted efforts include postings in the Transformation Center's bi-monthly Recovery Network News (RNN) e-bulletin, Boston Resource Center (BRC) and SERLC websites and emailing opportunities to neighboring RLCs for distribution within their networks. RNN is a significant resource, as many of its e-bulletin subscribers are CPSs. RNN's job posting is regarded as the most comprehensive listing of peer jobs in the Commonwealth. MBRLC leadership is well-connected to other organizations that post job opportunities and have access to potential candidates: NAMI, VA, Depression Bipolar Support Alliance (DBSA)-Boston, Casa Primavera, the Ruby Rogers Center, the Friends of Metro Boston, and its partners by subcontract (V and BC), with DMH Case Managers and on the new MBRLC website job page.

Family Partners and Peers will be active members of the ESP teams. As such, they will attend staff meetings and trainings with their clinical team-member colleagues. They will also attend weekly peer-facilitated support groups for Family Partners and CPS/Peers. Family Partners and Peers will also have regular individual supervision.

BC has hired, trained and retained many CPSs in programs such as CBFS, the Wellness Center, the Peer Education Resource Center and the BEST program. Family Partners have worked as part of MCI since the start of the CBHI. The BC CPSs meet as a group on a weekly basis and provide and receive peer supervision in this and other settings.

V's recruiting staff, accompanied by one of its Peer Workers, visits the GIFT (Gathering and Inspiring Future Talent) Training graduations to discuss opportunities available at the agency. GIFT has become desirable training that young adults seek prior to moving into the CPS training program. Peer Workers will be Mental Health Workers on the CCS. They will attend staff meetings and trainings with their colleagues. They will have individual supervision with the Lead Nurse or CCS Director. They will participate in the regional peer supervision provided by the Director of Recovery and have the option to attend the "Lunch and Learns".

2.4.3 Adherence to Recovery Principles

2.4.3.1 Professional Development Activities and Trainings: Please see Attachment 6.

2.4.3.2 Integration of Recovery Principles into Practice: BMC has involved Peers in various aspects of program planning and delivery since the establishment of the peer-run BRC in September 2005. The commitment BMC made at that time was to integrate the philosophy of recovery, strength-based approaches to treatment, and consumer choice and decision-making into every program within the BMC DoP. We have made much progress in this regard over the years. BMC received the DMH grant to lead both the MBRLC and the SERLC. There are Peers on the ESP Advisory Committee and on the Ambulatory Services Core Managers group. Peers participate in the orientation of ESP staff. When ESP Clinicians and other treaters convene to

develop crisis plans for clients, those clients are strongly encouraged to participate and to lead the development of a plan to guide future care. Peer members of MBRLC who will be integrated into the ESP assist consumers to develop Wellness Recovery Action Plan (WRAPs).

The treatment approach of BC is based on the belief that all individuals have the potential to grow, acquire skills and develop strategies to better manage everyday life and the effects of a mental health condition. This approach is demonstrated as BC works with individuals to assess their present strengths, preferences, goals and needs and incorporate them into the interventions. When available, natural or generic community supports, such as family or friends, are incorporated into treatment plans. BC embraces the tenants of the SAMHSA consensus statement on recovery.

V has taken significant steps to measure the degree to which its staff act in ways that promote the recovery of people it serves. It developed and instituted a data collection system focused on Quality of Life Outcomes (QOLO) to measure the effectiveness of the rehabilitation strategies and support it provides to clients. One of the measures included in the QOLO data is the Milestones of Recovery rating (MOR). This scale is completed monthly and measures a person's progress in his/her path to recovery using a 1-8 scale. Effective planning requires true collaboration with the client and targets interventions of the correct type and intensity. The goal is not to plan *for* clients, but to plan *with* clients. All new employees participate in 10 training modules (39 hours), with skill outcomes and learning objectives for all trainees. V has recently completed a two year process of mapping the competencies needed.

2.4.3.3 Anticipated Challenges and Mitigation Strategies: The medical and clinical leadership of BMC Psychiatry have been strong and vocal proponents for strength-based and recovery-oriented treatment for many years. In the spring of 2005, our Medical Director approached MPower and individual Peer leaders to enlist their assistance in establishing a formal presence at BMC. With BEST they have continued to nurture these efforts. The advances we have made over the intervening years make us optimistic that our ongoing challenges will continue to be minimal, as staff response and buy-in to our efforts has been enthusiastic.

BC and V anticipate minimal challenges to recovery-oriented services. The agencies will continue to promote this value through person-centered care planning, the inclusion of Peers and Family Partners in its programming, and ongoing teaching, training, and supervision of staff. BC and V will consider the cultural and linguistic needs of clients, staff, and community partners in the implementation of these practices.

2.5 Culturally Competent Services: BMC, BC, and V individually and collectively have long delivered culturally competent services. These providers recognize both the risk of disparities in access to effective care for racial, ethnic, linguistic and cultural minorities, and the significance of culture to the effective treatment of mental health and substance use conditions.

2.5.1 Population and Related Experience

2.5.1.1 Demographics: Ten percent of residents of Barnstable, Dukes, and Nantucket counties speak a language other than English in their home. Approximately two-thirds of those residents also speak English "very well". Six percent of the population of Cape Cod was born outside of the US, while about 10% of the residents of the islands are foreign born. More than three quarters of the residents of this area report western European descent. The other quarter of the population comes mainly from Brazil, Sub-Saharan Africa, and Cape Verde.

2.5.1.2 Experience Providing Services to Populations: BMC's BHS reflect the culturally rich ethnic populations it serves. More than half of BMC patients have an annual income at or below $20,420. About 75% of BMC patients come from under-served populations, including low

income families, elders, people with disabilities, minorities and immigrants. A first-of-its-kind program nationwide, the Boston Center for Refugee Health and Human Rights at BMC treats over 400 patients from more than 70 countries each year providing comprehensive health, social and legal services to refugees, asylum seekers and survivors of torture. Thirty one percent of BMC patients do not speak English as their primary language. BMC's medical interpreter staff provides in-person coverage for 24 languages to assist in emergency psychiatric evaluations. Approximately 190 additional languages are available for telephone interpreting. BC has overseen services to cultural and linguistic minorities since the 1990's. BMC will link with its partners, BC and V, to address the ethnic minorities identified in the CCI-ESP area.

The demographics of the CCI-ESP population are well known to V. The staff has experience working with clients from different cultures and has designed rehab plans to meet specific cultural beliefs and practices, including Western European, Cape Verdean, Sub-Saharan African, and Brazilian newcomers. These practices have included adjusting engagement strategies and developing culturally relevant community supports for clients. V hires staff to reflect the cultural diversity of the communities served and ensures that there is full integration in both direct service and management roles. Staff assist clients in making connections back to resources within their cultural communities, a powerful tool in a person's recovery.

2.5.1.3 Culturally and Linguistically Appropriate Programs and Staff: BMC has no specific culturally- and linguistically-tailored program models that are currently operated, with the exception of Latino team in the child ambulatory services. Though BMC has considered pursuing this approach to treatment services, it was not thought to have been feasible because of the sure number of ethnic minorities seen at BMC and/or its affiliated health centers. Also, BMC believes it crucial to increase the cultural competency of all providers.

V's La Casa Hispania residential program serves people who share similar cultural heritages, most of whom do not speak English. La Casa staff are Spanish-speaking and bicultural. The services are designed and delivered with cultural sensitivity. V runs the CBFS in Lowell, home to the second largest number of newcomer Cambodians in the country (10.37%), and to a large number of those of Hispanic descent (14.01%). As many Cambodian refugees have experienced significant trauma in their homeland, V's trauma-informed approach has enhanced its work with residents of the CCI who may have relocated experienced trauma in doing so. They have hired Cambodian and Hispanic staff to work with these clients. V provides staff with historical and cultural information (attitude, family influence) and how these impact the client's mental health. V currently serves individuals who are Hispanic, Latino, Haitian, or Asian in many of its sites and employs this approach in each program it operates.

BC has long operated specialty residential and clubhouse programs serving Spanish, Vietnamese, Cantonese, and Mandarin speaking adults. The programs are staffed by employees from the respective cultures who are minimally bilingual. BC also operates two specialty CBFS teams who work with these populations.

2.5.1.4 Efforts to Engage Populations Who Underutilize ESP Services: BMC will use natural community resources to outreach to ethnic and linguistic minorities. This will include outreach to entities such as faith communities, schools, and local newspapers. BMC will also utilize educational opportunities such as health fairs to educate individuals regarding PES and mental health issues and will seek input directly from communities regarding outreach strategies.

2.5.2 Organizational Capacity

2.5.2.1 Capacity to Provide Culturally and Linguistically Competent Services

2.5.2.1.1 Current Composition of Governance and Senior Management: BMC recognizes the importance of diversity at all levels of the institution, including the Board of Directors and the senior leadership responsible for the governance and oversight of this ESP. Twenty five percent of BMC Senior Management Team and the Board of Directors are of cultural/ethnic minority. Ethnic minorities compose approximately 15% of the senior leadership team responsible for the oversight of the ESP program.
2.5.2.1.2 Board of Directors' Initiatives to Strengthen Cultural Diversity: During the past several years, BMC has undertaken several initiatives to increase cultural diversity in its workforce and management team. These are described in Attachment 7.
2.5.2.1.3 Number of Bilingual/Bicultural Staff and Reflection of MassHealth-Enrolled Population: Forty-two percent of the BMC ESP Mobile Teams and CBL staff are bilingual, as are 24% of the Call Center staff and 45% of the clinic staff. Spanish is the most common linguistic capacity reflected in the BMC behavioral health staff. Minorities represent 64.2% of V's staff (Black/African American are 52.8%; Hispanic/Latino are 6.8%; Asian are 1.4%). In addition American Indian/Alaska Native, Hawaiian/Other Pacific Islander and those with two races are represented as well. White/Caucasian represent 35.8% of V's workforce.
2.5.2.1.4 Interpreter Services: BMC recognizes that it is necessary to maintain a stellar interpreter service in order to provide excellent medical care. In addition to providing face-to-face interpreters on-site in 24 spoken languages, American Sign Language, and Certified Deaf Interpreting, the department utilizes the latest advances in technology such as telephonic and video interpreting, in order to provide around the clock interpreting services to patients in 190 languages. V and BC arrange external consultation to staff; provide ongoing site based training to improve staffs' cultural competence; continuously work to build relationships with community agencies; and use family/social supports with client consent for translation/interpreter services. They are also committed to hiring bilingual/bicultural staff who speak clients' languages.
2.5.2.1.5 Professional Development Activities and Trainings: Please see Attachment 6.
2.5.2.2 Delivering Culturally- and Linguistically-Competent Care: BMC's DoP has a rich and longstanding history of providing care to a diverse patient population. Their approach to diversity and commitment to cultural competency can best be expressed in BMC's diversity statement, "the Medical Center remains committed to creating and sustaining a work place and a hospital where employees, patients, and patients' families are respected and valued not in spite of, but because of the differences in their backgrounds and cultures". Honoring the diversity of communities will promote and ensure mutual respect, collaboration, and productivity necessary to provide the highest quality care. This perspective that has informed BMC's psychiatric services. Please see Attachment 7.

V's staff receive ongoing site based training on cultural competence to ensure sensitivity to the impact of culture on clients' identity, beliefs and experience of their illness. V ensures that staff are sensitive to each client's unique needs and prepared to adapt clinical interventions and treatment based on culture and ethnicity. V recruits a diverse staff, accesses translators when necessary, respects and celebrates cultural differences, and links clients to culturally relevant community supports.

BMC, BC and V anticipate the need to serve clients who are diverse in terms of gender identity and sexual orientation. They orient, train and supervise staff to respect all clients, and to demonstrate sensitivity and acceptance of their sexual orientation and gender identity.
2.5.2.3 Institutional Initiatives to Strengthen Cultural and Linguistic Competency: Efforts in this area are documented in Attachment 7.

2.5.3 Experience Partnering with Minority, Community-Based Organizations: BMC and its DoP have extensive experience in linking with other community-based organizations and in meeting the service needs for refugee/immigrant populations. BEST has as a key element of its design linkages with community based organizations. BMC also has a multi-service Center for Refugees which was founded and organized within the DoP at BMC.

BC and V have partnered with community organizations that teach English as a second language, provide cultural connection and social options for clients, and translation services, including community action committees, public libraries, community colleges, counsels on aging, churches and other faith based organizations, and the Massachusetts Commission for the Deaf and Hard of Hearing.

2.6 Other Special Populations

2.6.1 Elders: In 2010, ESP clinical staff acquired online certification in the assessment of elders from the Boston University Institute of Geriatric Social Work. This was initially sponsored by MBHP and additional training slots were paid for by BMC to solidify core competency of BEST clinical staff. BEST has continued to provide services to elderly clients and agencies serving elders and various other programs, especially when a home-based assessment is the most comfortable and most appropriate for the client.

BC, through Kit Clark Senior Services, has an integrated continuum of services that provide support for about 4,000 elders each year. Services include Adult Day Health, residential support, Meals on Wheels and the Medeiros Center for Change, the first and only shelter for older adults in Boston. Staff conduct the programs in five different languages.

The existing V services and programs have a solid record and strong commitment to providing BHS to individuals in place as they age. As clients grow older, V honors their desire to "age in place" by enhancing services with ongoing access to nursing staff. V staff know how to modify sites, convert their use, and adjust interventions to meet the developmental needs of older clients.

2.6.2 Veterans: The metro Boston area has a dense population of veterans, including homeless and/or disabled veterans and has a significant array of behavioral health, medical, and housing/shelter services for this population. BMC has strengthened its understanding of the needs of this population and the resources available. BMC's role with the MBRLC offers an important resource. BMC psychiatry residents do rotations at both Bedford and Boston VA Medical Centers. Those residents also treat BMC patients through the ESPs and clinics.

From 2003-2011, V ran the Peer Education and Support program for veterans (Vet to Vet). The critical components of the Vet to Vet program are mutual support, promotion of individual responsibility, leadership, self-advocacy, self-determination and participation in the recovery process. V provided this service in 41 sites to approximately 1200 veterans.

Veterans receiving services through the ESP will be referred to housing programs, addiction services, community based treatment and more acute services when presenting with high acuity.

2.6.3 Persons Who are Homeless: In 2015, 30% of BEST encounters were for homeless individuals and/or families, as is typically characteristic of the urban environment. Consequently, the metro Boston area is rich in resources for this population. BEST recently partnered with the Pine Street Inn by deploying an ESP Clinician on a regular walking route with one of the Inn's Street Outreach Clinicians in order to help address the emergency mental health needs of high risk homeless individuals. This initiative proved successful in terms of reaching out to difficult-to-engage mentally ill (and typically untreated) individuals; strengthening the assessment

capacity of these homeless outreach initiatives; and enhancing the core competency of the ESP vis-à-vis homeless populations.

Both V and BC have more than 30 years of experience engaging homeless adults with serious mental illness and co-occurring addiction in housing and supports through PACT, clubhouses, CBFS, and specialized rehabilitative and employment supports. V's Dudley Inn Safe Haven uses a "Housing First" philosophy to help people who have experienced long-term homelessness to live at the Inn and eventually work toward permanent housing. It offers medical and psychiatric care on site and helps with daily living skills, and housing search services. V's Homeless Outreach Team serves 140 homeless people each year with psychiatric conditions on Cape Cod helping connect people in need with supports. BC has extensive experience serving homeless adults with psychiatric and addiction disorders, operating the Boston Night Center, the Albany Street "wet" shelter comprising 100 beds in Cambridge and other programs.

2.6.4 Persons with Substance Use Conditions: About 35% of BEST encounters involve individuals with substance abuse or dependence disorders. As such, BEST clinical staff have well-honed assessment and intervention skills. Within BEST's partner agencies' cadre of services there is a rich continuum including: outpatient addiction services and dual diagnosis outpatient treatment services, inpatient detoxification, outpatient methadone, Enhanced Addiction Treatment Service (EATS), SOAP, Adolescent SOAP, school-based addiction education and support, and residential treatment. Close collaboration with ESP has enhanced its effectiveness in needs-appropriate linkages and care access for clients. Ongoing trainings on substance abuse assessment, treatment and motivational interviewing have been provided to BEST Clinicians. Several Psychiatrists within BMC's behavioral health clinic are certified to provide Suboxone treatment.

Approximately 10% of individuals presenting at the CCS at Cape Cod are struggling with substance use conditions. BMC will employ a harm reduction approach and access substance treatment programs services as indicated and desired by the stage of readiness of the client

2.6.5 Persons with Co-Occurring Mental Health and Substance Use Conditions: In 2015, 65% of BMC ESP encounters involved persons with co-occurring mental health and substance abuse conditions. ESP Clinicians have a strong orientation toward assessing and understanding the needs for this client population. Training for this population has been included in program wide and component-specific trainings. Treatment integrates engagement strategies, medication assistance, psychosocial education, supportive counseling, and peer support, available to all clients regardless of "readiness" for abstinence or interest in treatment. V and BC have relevant experience and expertise in the implementing such programs.

2.6.6 Persons who are Deaf and Hard of Hearing: BC utilizes DPH interpreter services for persons who are deaf and hard of hearing. V also provides services to such individuals. It uses interpreters to assist in ensuring culturally competent, person centered services are provided. It has had clients in its CCS, CBFS, outpatient, and DDS services access these supports.

2.6.7 Persons who are Blind, Deaf-Blind, and Visually Impaired: The BMC ESP does not currently have expertise in this area; however, to further develop competencies in serving special populations, it would seek consultation from the Massachusetts Commission for the Blind, including its Deaf/Blind Multi-Handicapped Services. Also, the Director of the peer-run BRC is sight impaired and has provided consultation and training to ESP staff.

2.6.8 Persons who are Department of Mental Health (DMH) Involved: BMC ESP has a very close collaborative relationship with DMH in the metro Boston Area. Communication and collaboration are enhanced by virtue of BMC Psychiatry and ESP senior administration, the Call

Center, CBLs and CCSs being located in two of the state office buildings that house DMH services. ESP provides consultation and MCI to DMH programs and venders throughout the area. Mobile Team supervisors and the ESP Clinical Director participate in risk review meetings and crisis planning for DMH-eligible individuals. BEST provides a DMH-specific respite bed on its CCS. BMC's close collaborative relationship with DMH has resulted in smooth and efficient delivery of services to DMH clients and greater satisfaction from DMH and vendor providers. The BMC ESP MCI Director works closely with DMH/DCF Caring Together program.

V's PR Division is dedicated to the recovery of more than 5,000 adults and transitional age youth living with psychiatric disabilities, substance addiction, and/or HIV/AIDs. Much of the service provides to these individuals is funded by DMH. The majority of services are outreach-oriented assertive community treatment serving 2,700 clients via CBFS and PACT services. V provides many other services including CCS, RLC, and Safe Haven, among others.

BC provides many services to people also served by DMH. PACT staff provide needed services in a personalized and integrated way. The PACT model is uniquely responsive in that the team operates seven days a week and is available by telephone twenty-four hours a day. BC's CBFS serves 1,100 adults living in Boston. Additional services offered by BC are the Safety New Outreach Team, the Michael G. Gill Wellness Center, the Gill Clinic, Center House Day Treatment, Transitions of Boston and The Boston TPP.

2.6.9 Youth and Families who are Department of Children and Families (DCF) Involved: BMC ESP has significant involvement in providing crisis services for DCF-involved children and families. In order to ensure effective and efficient coordination of services, the ESP and the four Boston area DCF offices collaborate on a crisis planning initiative (recognized by former DCF Commissioner Angelo McLain as a best practice). Monthly and as-needed meetings facilitate coordinating care and planning for individuals who have been high utilizers of services or identified as high risk. Often, these meetings may take place at the point the client is being discharged home from a hospital. All involved providers, family members, and the child/adolescent are encouraged to participate. The written crisis plan remains in the ESP EMR system, and in the DCF online records system, for easy access when a crisis evolves. Overall, providers and consumers have reported positive satisfaction, and data has indicated a significant drop in re-admission rates. This process has improved lines of communication and collaboration between BMC ESP and DCF area offices. The BMC ESP MCI Director works closely with the DMH/DCF Caring Together program.

V staff work with youth in the Transition to Independence Program (TIP) who are in DCF custody and with adults whose children are in custody of DCF in CBFS. Staff maintain a collaborative relationship with DCF staff, as allowed by the client and/or guardian, often to coordinate care and plan for individuals who have been high utilizers of services or identified as high risk.

2.6.10 Youth and Families who are Department of Youth Services (DYS) and/or Juvenile Court System Involved: BMC ESP sees a significant number of youth in the DYS system. Within the current catchment area there are two DYS locked facilities, which utilize the ESP on a frequent basis. Meetings are held on a regular basis between the ESP UCC Directors and the DYS Clinical Coordinator and other family members and providers to develop crisis plans often centered on hospital diversion. BC has worked with DYS in developing risk management and screening protocols for high risk clients. Overall the relationship with DYS has been very strong and has resulted in effective service delivery and excellent client care. V staff have similar experience with DYS as described above in 2.6.9 with DCF. BC BEST and DYS have a close

collaborative partnership. After two completed suicides in DYS facilities, BEST was invited to help create screening protocols for detained and committed youth in DYS. To date this partnership is one of the closest collaborations BEST has with community providers.

2.6.11 Youth who are on the Autism Spectrum: BMC's Autism Resource Program assists and empowers those affected by autism spectrum disorders through direct patient support, provider education and community based trainings in a culturally competent manner by offering high quality and comprehensive care to all. The program also provides psychosocial support and resource assistance to families in the program. The in-clinic and online comprehensive Resource Libraries compile various resources to educate, inform, and support providers and families in navigating an autism diagnosis, and subsequent issues or concerns that may arise.

2.6.12 Persons receiving services from the Department of Developmental Disabilities (DDS): The BMC ESP's distinct, dedicated 24/7 crisis intervention team for recipients of DDS services receives partial funding from DDS. Individuals with developmental disabilities generally benefit from a specialized intervention. Inpatient admissions can often be diverted by linking the natural support system with increased formal supports, or by troubleshooting and addressing environmental issues that may be causing behavioral outbursts or other high risk behavior.

V offers a comprehensive array of services for individuals with intellectual and developmental disabilities, autism, visual and hearing impairments, and physical disabilities. It partners with individuals, their families, their employers, and their communities to help people receive the services they need to achieve their goals and attain independence. V supports nearly 1,000 individuals in 80 service settings in Massachusetts.

Both BC and V offer extensive residential and day services for adults with development and intellectual disabilities, including specialized group homes (intensive medical, behavioral, addiction, and forensic), day habilitation, and employment and community based day services. BC also offers family support, supported housing and individual support services for youth and adults with development and intellectual disabilities. Both V and BC have Board Certified Behavior Analysts (BCBAs) that direct their behavioral and clinical services.

2.7 Intersystem Planning and Affiliation: The target consumer populations have complex social, medical and behavioral health needs which are typically met through a diverse, and sometimes not well integrated, array of services in the community. BMC and its partners have been talking with a variety of community agencies within the CCI-ESP area. In these discussions, we have shared our philosophy and experience in delivering ESP services in metro Boston, and have asked them to inform us about the attributes of the population they serve, their service needs, and any gaps identified in the current ESP delivery model. This information has helped inform the program design for this proposal. We have also asked representatives from these agencies to continue to work with us, should we be successful in our bid; this includes being represented on our ESP Advisory Committee. Below we describe our approach to engaging these diverse parties in planning efforts and developing working affiliations.

2.7.1 Experience Convening Collaborative Structure: BMC has successfully developed Advisory Committees for its ESPs, to review trends, service gaps, and barriers, and to identify potential remedies for identified issues. The committees also provide direct feedback to ESP leadership on performance. BMC ESPs also convened area CBFS vendors and other stakeholders in a Safety Forum to create and communicate inter-agency protocols across 24/7/365 systems. BMC ESP representatives regularly participate in newly forming and existing community forums where system strengths, barriers, trends, and opportunities are identified and discussed.

2.7.2 Processes and Structures to Collaborate with Other Stakeholders: If successful in this bid, BMC will replicate its effective model of intersystem planning and collaboration in BEST for the past 12 years. That is, the ESP Clinical Director, MCI Manager, and the Managers of the CBL/Mobile Teams will meet regularly with DMH (including participation in risk management meetings), DCF (including regular development of crisis plans for shared clients), staff and leaders of DYS facilities, DDS, Medical Directors of the EDs in our service areas, school personnel, police officials, courts, and shelter system representatives. In these meetings, we invite feedback on services provided and will engage with our community partners.

BMC will convene an Advisory Committee, as BEST has been doing, comprised of representatives of key stakeholders, including agencies in the service area, consumers, the Parent/Professional Advocacy League, the Massachusetts Chapter of NAMI, homeless services, substances abuse services, DCF, DYS, DMH, public schools, area police departments, and ESP leadership staff. The committee will provide the essential stakeholder perspectives and expertise necessary for continued ESP quality and service improvement. We would also be involved in existing area forums and lead developing forums as issues present.

2.8 Initial and Ongoing Training, Monitoring, and Evaluating Staff and ESP Program: Program goals, mission and philosophy are clearly described to candidates during recruitment for each ESP component. We emphasize the investment and belief in the power of community-based evaluation and the use of diversionary services to best serve clients and stakeholders. Hiring Managers seek applicants with strong community experience and commitment to these shared values. All new ESP hires are oriented to all ESP components, the content of which is reinforced through required monthly all-ESP staff meetings devoted to training or continuing education. For several years, consumers have trained ESP staff (e.g. "In Our Own Voice" and "Principles of Recovery" presentations) and staff have worked with consumers and Peers from the BMC-led MBRLC and SERLC. ESP clinical staff members receive regular supervision during which each Clinician's cases and records are reviewed. This vehicle serves both as a teaching opportunity (e.g. around assessment and clinical decision-making) and as a way to review the staff member's knowledge of community resources and diversionary services for ESP clients. The ESP electronic record has embedded reports that allow the Clinician and supervisor to review data elements. Call abandonment rates and other information is available in the electronic call log for the Call Center. This information is available both by team and by Clinician, provides timely feedback, and can facilitate practice improvements.

Emergent needs for additional policies, systems and programs are discussed at the weekly Clinical Leadership Committee meeting. Any changes to the goals, philosophy, and business approach must be discussed and approved by the committee to ensure consistency of practice across all components of the ESP. The committee devotes time to discussing strategies to improve diversion rates from ED and inpatient hospitalization. Similar conversations occur at staff meetings. The Clinical Leadership/QM Committee reviews ESP performance in relation to key performance specifications required by payers ongoing. Data collection and report mechanisms built into the EMR system facilitate BMC's review of current and factual information. This year, BMC began an annual review of the ESP and staff members based on the BMC Universal Performance Standards, including putting the client first, customer service, teamwork, communication, and professionalism.

3. ESP Service Components

3.1 Emergency Services Program (ESP)

3.1.1 ESP Program Model: Prior to seeking the BEST contract for Boston in 2003, BMC surveyed key consumer, advocacy, provider and public safety stakeholders to request their input in the proposed program design. The ongoing Advisory Committee comprised of stakeholders meets bi-monthly to provide continuous feedback on BEST performance and to generate solutions to questions and challenges that arise. If this bid is successful, we plan to replicate this process of engaging with stakeholders to carry our ESP model, described in more detail below, into the CCI area.

Our program is based on the principles of: 1) upstream timely access and response; 2) seamless integration of ESP components; 3) community knowledge and linkages; 4) strengths-based and person-centered interventions; 5) services congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served; 6) recovery, empowerment and peer support; and 7) staff competencies in community-based crisis management and resolution. These principles are embedded within all elements of our program and their linkages.

The strength of BMC BEST is the partnerships we have developed with our sub-contractors and leverage to provide seamless services. Strong oversight by BMC as the lead agency emphasizes cohesion, communication, and uniform practices. Services are delivered via specialized components that work as a team to manage crisis encounters. These components for CCI-ESP will be the centralized 1-800 BMC Call Center number staffed by master's level Clinicians; BMC Psychiatry clinical leadership providing 24/7/365 supervision, consultation and administration; the BC Mobile Team that will dispatch from community-based locations; and a seven-bed CCS operated by V, co-located with BC at the primary CBL site.

Our model uses a "discrete level of care" for individuals in behavioral crisis that is more robust than a simple screening and triage program. BMC BEST provides a highly integrated system of acute behavioral services with clear linkages to other elements of the system of care. Our program cares for individuals for discrete periods of time until the acute behavioral crisis ends or until the individual can be safely connected to other levels of care, often within the ESP itself and such as follow-up visits, urgent psychopharmacology and crisis stabilization at our voluntary unit. When medically necessary, persons in crisis are connected to the appropriate level of care within the broader community continuum, as well as social services and natural supports.

Our experiences over the past 12.5 years in caring for individuals until they are bridged to community supports helped establish our family and youth-focused seven-day crisis stabilization option using Mobile Crisis Intervention. It enables our ESP to respond to the evolving nature of the community-based behavioral health system for people of all ages.

3.1.2 Changing Perceptions: We will build upon our success in the current BEST to promote the principle of ESP as a discrete level of care in the CCI area. Already, we have met with representatives of major community-based providers, peer and essential services working with children, adolescents and adults in the catchment area. They have made initial commitments to collaborate on a comprehensive crisis response system as reflected in the Letters of Support Attachment. Building a community continuum of crisis response helps all parties understand the individual's needs, preferences and history; intervene earlier in the crisis; and resolve the crisis in the least restrictive manner thereby enhancing the individual's self-efficacy and community tenure.

3.1.3 Realizing the Vision and Managing ESP: In order to realize our vision for a robust CCI-ESP and manage this critical service effectively, we will employ the following strategies:

- Use of regular communication regarding policies and practice across all components of the ESP: meetings, supervision, daily phone contact, trainings, utilization review, case conferencing;
- Documented policies and procedures as reviewed and endorsed by all component leadership; and
- Emphasis on hand-off protocols. See Attachment 8 for BC Report as an example of existing protocols for shift change and coordination between teams. See Attachment 9 for de-identified BC case tracking sample. The case tracking document is accessible by all BC staff to ensure coordinated assignment and follow up.

3.1.4 Fluidity among Service Components: Our cross-functional team will support each other to cover upward fluctuations in volume. The Call Center serves as the central information and support component, aware of case flow and assisting Mobile Teams in juggling their responsibilities. Supervisors with administrative duties will support cases as required by demand.

Similarly, Mobile Team Clinicians, when available, will provide additional clinical services to CCS as well as support to psychopharmacologists providing urgent bridge medication appointments.

The EMR will track response times to help identify outliers and barriers that need attention. The Call Center will triage every request for service, and in those instances of lower acuity, will work with the caller to arrive at a mutually agreed upon opportunity for assessment and early intervention.

3.1.5 800# and Triage Function: Our toll-free number serves callers 24-hours a day, seven days a week. By using the 1-800-981-HELP Call Center, a caller is provided with support, information, referral or evaluation. Calls made to the Call Center are screened for intake, evaluation, and assessment. The Call Center may dispatch a crisis intervention Mobile Team to the site of the crisis, direct the individual to an UCC/CBL, or, when unavoidable due to safety or medical acuity, direct the party to an ED.

The Call Center serves as the nerve center of the ESP. The Call Center maintains live management of cases being seen throughout the ESP system and works to triage new cases according to availability of staff. In addition, the Call Center provides support, information and referral for the many callers who are not requesting evaluations. The Call Center works closely with the Metro Boston/SERLC Peer Support Line which also serves the CCI-ESP area. The Call Center links callers who need to talk to the Peer Support Line. In times of high demand, Call Center Clinicians support the Mobile Teams by completing the final assessment stages (e.g., bed searches, linkages to community-based programs, and shift change transfers).

The Call Center is staffed by master's level Clinicians to offer exceptional clinical expertise and crisis management. Staffing is at the highest level during peak hours of calls, 9 a.m. to 11 p.m., with two Clinicians answering calls from 11 p.m. to 7 a.m. The first day-shift Clinician takes over at 7 a.m. and is quickly supported by the next, who arrives at 8 a.m. Additional staff is staggered throughout the day, with peak hours served by a minimum of six Clinicians on weekdays and four on weekends.

3.1.6 Covering the Entire Catchment Geography: We anticipate establishing one CBL in the catchment area. However, opportunities exist to use the continuums of care of our partners V and BC, as well as other community-based services as described throughout this application, to establish "outposts" for Mobile Team utilization. Clinicians will also be dispatched from home.

3.1.6.1 One-Hour Response Time: In the CCI area, variables concerning geography, particularly with any need to move on and off the islands, and effects of longer driving distances will be considered during response time analyses. Our plan includes recruitment of staff who live on the islands to work for the ESP at those locations. Using ESP and other community partners' locations as outposts will be needed on the Cape and require further development. Clinicians will not always report to an office but rather will be dispatched directly from home. Having a web-based EMR and other technology, such as cell phones and iPads, offer greater flexibility for locating staff throughout the catchment area.

3.1.7 Rationale for Variances in Service Model: BMC's current ESPs operate an 800# Call Center that is situated with a community-based location of the Boston ESP. In serving the CCI, we propose to expand the Call Center's responsibilities to the new area. Though not co-located with the CBL under this proposal, use of the existing Call Center represents an efficiency gained through economies of scale. Given that the entire ESP is connected by an EMR that operates in real time, and with other technological options for communication, we believe the skill and experience of Call Center staff outweighs benefits gained from co-location. The call volume, triaging and dispatching duties of the Call Center, as well as the additional responsibilities involved in backing up Mobile Teams (e.g., coordinating bed searches and accessing consultation resources), can all be integrated for multiple catchment areas. The ESP Cost Report details additional new call center staff.

3.1.8 Location of Services

3.1.8.1 Locations and Hours of Operation: While the ESP will have a primary CBL, we will also try to partner with community agencies to establish "outposts" in the catchment area where Mobile Clinicians can be staged in order to reduce response time

Service Component	**Address Where Service will be Delivered/ Dispatched from**	**Days/Hours of Operation**		**Other Services at this Location**
		Of the Service Component	**Of the Physical Site**	
ESP Senior Management Functions	85 E. Newton St. Boston, MA 02118	24/7/365	8a.m.-5p.m, M-F	800# and Triage; existing BEST CBL/CCS
ESP Director; MCI Manager	TBD	24/7/365	8a.m.-5p.m., M-F	TBD
800# and Triage	85 E. Newton St. Boston, MA 02118	24/7/365	24/7/365	ESP Senior Management; existing BEST CBL/CCS
Community-Based Location	270 Communication Way, Hyannis	24/7/365	24/7/365	Mobile Teams; CCS
MCI	270 Communication Way, Hyannis	24/7/365	24/7/365	Adult Mobile Team; CCS; CBL
Adult MCI	270 Communication Way, Hyannis	24/7/365	24/7/365	Youth Mobile Team; CCS; CBL
Adult CCS	270 Communication Way, Hyannis	24/7/365	24/7/365	Mobile Teams; CBL

RAP (Runaway Assistance Program)	270 Communication Way, Hyannis	4:30p.m.-8p.m., 24 hours/day weekends and holidays	NA	

3.1.8.2 Location and/or Substantive Physical Plants Changes

The current CCI-ESP operates at 270 Communication Way, Hyannis. If successful in this proposal, we will continue to use this space for the CCS and add the CBL. The center is well-known and accessible to the community. While the space may need some reorganization to house the Mobile Team, it represents a logical choice to continue with ESP services.

3.1.9 ESP Management

3.1.9.1 Qualifications/Resumes

3.1.9.1.1 ESP Director (not yet hired): Per requirements of the Massachusetts Privatization Law, recruitment for a qualified ESP Director will include consideration of individuals working with the current ESP and terminated as a result of DMH no longer providing the ESP services. Full qualifications of the ESP Director are described in Attachment 10.

3.1.9.1.2 Quality/Risk Management Director (not yet hired): Per requirements of the Massachusetts Privatization Law, recruitment for a qualified Quality/Risk Management Director will include consideration of individuals working with the current ESP and terminated as a result of DMH no longer providing the ESP services. Full qualifications of the Quality/Risk Management Director are described in Attachment 11.

3.1.9.1.3 Medical Director: See Attachment 12 for resume of current Medical Director.

3.1.9.2 Organization Chart: See Attachment 13.

3.1.10 Psychiatry Staffing: BMC BEST currently meets the psychiatry standards of the Request for Response (RFR) performance specifications and will use this experience of providing 24/7/365 services to staff the CCI-ESP. BMC will provide all needed psychiatry services, including both direct and on-call services. BMC has adult and child-qualified practitioners as well as Psychiatrists and Clinical Nurse Specialists on-staff through its DoP and will hire as needed to provide expanded ESP services. The CCS unit will have daily face-to-face rounding with either a Clinical Nurse Practitioner or Psychiatrist. A Psychiatrist will be on-call 24/7 for consultation with CCS and Mobile Teams, both adult and child. Clinical Nurse Specialists will provide urgent psychopharmacology appointments for ESP referral.

BMC possesses within its ranks, a broad range of discrete capabilities to treat children, adults, elders and their families. BMC DoP is highly regarded for its staff competencies to treat trauma, neurological conditions, other co-occurring behavioral and medical conditions, and acute care situations.

3.1.11 Safety: The proposed CCI-ESP will employ several strategies to assure safety, including:

- The Call Center assesses risk by report of referral source, person(s) on-site with individual to be evaluated, and by reference to past electronic records;
- Use of two-member teams when needed clinically or due to question of safety;
- Request for police to meet at community site, if situation merits;
- No fewer than two staff will be onsite at the CBL at any given time; and
- Adherence to current BEST Policy, *Response to Requests for Community-based Evaluation in Situations Felt to be Dangerous*, Attachment 14, with said policy to be amended to reflect catchment area.

3.2 Community-Based Location: BMC and its partners are well known for their practice of providing highly accessible community-based locations for even the most acute and secure services to children, adults, elders and their families. We recognize that both unique characteristics of our client populations and best treatment practices demand accessible, community-based care settings.

3.2.1 Community-Based Locations

3.2.1.1 General Description: The CCS currently serving CCI is located at 270 Communication Way in Hyannis, in space leased by V. There is space available at the location to accommodate the Mobile Team, and offer qualities and features including convenient access, parking, a modern and well maintained building, clear signage, multiple areas for reception, assessment and other staff functions.

3.2.1.2 Rationale for Location: This site is located in one of the mostly densely populated sections of this region, and is adjacent to Route 6, the Cape's main thoroughfare, and a short drive from the Hyannis island ferry terminals.

3.2.1.3 Rationale for Perception of Community-Based Location: The site is located in an area with numerous commercial establishments nearby, including the Cape Cod Mall and Barnstable Municipal Airport.

3.2.1.4 Proximity and Access to Public Transportation: The site is served by buses from all parts of the Cape through the Hyannis Transportation Center and local service provided by the Cape Cod Regional Transit Authority.

3.2.1.5 Physical and Interpersonal Climate: The Community-based location will be painted in soothing colors and decorated to create a warm, calming environment. Care will be taken to decorate and purchase furniture which provides a comfortable environment, as opposed to an institutional feel. Food and beverages will be available at all times. Space will be dedicated for a play area for children, which will include toys and books. Creating a positive interpersonal climate begins with our staff. Every employee of the ESP and CCS will be encouraged to focus on the following principles in their work with people in crisis: putting consumers first, trust, teamwork, open communication, integrity, professionalism, flexibility, adaptability, and accountability. Peer Specialists will be especially well-placed to offer support regarding the process of assessment and what to expect as matters unfold.

3.2.1.6 Differentiating and Communicating Crisis Behavioral Health Services: Access to the site will be controlled in a humanized way (e.g. minimal to no use of intercoms or door buzzers to allow entry), individuals entering the site will be greeted in a reception area where they will be welcomed and the purpose of their visit, if not already known, will be determined. What each person entering the site can expect during their time there will be explained to them, indicating in a compassionate way that they are there for a particular reason, and should expect an organized response to their presence. Individuals who present for the apparent purpose of social support will be directed to other resources, e.g. RLC, Peer Support Line, Parent Support Line, or Clubhouse program.

3.2.2 Community-Based Locations Supporting Goals of ESP

3.2.2.1 Community-Based Location's Support of ED Diversion: One of primary goals of our current ESPs is to divert behavioral health utilization from the hospital EDs. As part of this effort, it is critical to provide a community-based location that is well-publicized, accessible, and welcoming. The fact that the site is not located in a hospital setting is known to have a positive effect on diverting activity away from EDs. It has been demonstrated that community-based dispositions occur at a significantly higher rate when the ESP is community--not hospital--based.

Transportation services will be arranged for in advance to deal with times when the volume of individuals presenting for ESP services is so great that services at the ESP site will be the preferred option. This strategy is another way to divert from EDs, even when the ESP is operating at high capacity. The location creates opportunity to calmly focus on the issues at hand without the pressures of a high intensity, potentially trauma-infused medical emergency setting.

A challenge in the CCI area will be introducing clients to a new site, given that the DMH site presently used for CBL will not be available. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients who present at the Pocasset Center (Cape & Islands Mental Health Center) in crisis are triaged with the ESP and not referred to an ED.

3.2.3 Staffing

3.2.3.1 Flexible Use of Staff: All staff within the ESP will be cross-trained to serve multiple functions within the entire ESP and flex between components as part of the daily expectation. Co-location of the CCS with the community-based location and the use of fluidly trained staff will enhance the ability to respond to varying levels of demand and share resources. For example, the CPS may run a group at the CCS, then accompany a Mobile Clinician for an evaluation at a client's home.

3.2.3.2 Certified Peer Specialists: In many instances the most important intervention is the one in which the client is seeking help for the very first time. The clinical transaction that takes place can determine whether that individual continues on his or her path to recovery or walks out feeling less than hopeful. Our CPS work side by side with Clinicians to create a welcoming and hopeful intervention. Our Peers are essential team members and help Clinicians visualize and engender hope on behalf of the clients and families we serve. Peers function flexibly on the service facilitating interventions at the community-based location and in the community alongside Mobile Crisis Clinicians. For example, a Peer followed up with a client who had been made frequent 911 calls to communicate her distress to police. Once it became clear that the client was not in need of clinical resources, the Peer and client came up with a list of resources that the client felt would be helpful to her when she was distressed. After this intervention, her 911 calls stopped altogether.

3.3 Adult Mobile Crisis Intervention

3.3.1 Adult Mobile Crisis Intervention Services: BEST is governed by the philosophy that most behavioral health crises can be effectively addressed in the community. There is an ingrained culture among the current emergency services staff that unless there is an emergent medical or safety concern, evaluations should occur in the client's natural setting. BEST recognizes that providing emergency services on a mobile basis requires a special set of skills on the part of the Clinician, accessibility and support from the supervisory level and an understanding within the community as to the benefits of providing this service outside of an ED. We will expand this existing philosophy and culture throughout the new catchment area.

Mobile Clinicians will be based at the community-based location between the hours of 7a.m. and 11p.m. Between the hours of 11p.m. and 7a.m., two Clinicians will be available to respond on an on-call basis. Calls for services will arrive at the Call Center, staffed 24/7/365 by Masters-level Clinicians trained in crisis intervention and management. Triage Clinicians will respond to the needs of the caller and, following an assessment, make a decision whether to dispatch a Mobile Clinician. The Triage Clinician will document in the web-based system the person's demographic information, location in the community and description of the presenting problem. This information will be instantly accessible to the Mobile Clinician. Mobile Clinicians

will then drive to the location of the individual and provide crisis intervention, evaluation and stabilization services. Depending on the location and severity of the presentation, Mobile Clinicians will team up with a Master's Level Intern, Bachelors Level Staff or CPS. In some circumstances they may request the support of the local police department.

Mobile Clinicians will be equipped with cell phones and laptop computers with secure/encrypted wireless internet access. Clinicians will have the capacity to document their evaluations on the web-based system from any location in the community. If the Mobile Clinician needs to immediately dispatch from one location to another, their evaluation will be instantly accessible to other members of the team, who can proceed with a bed search or assist with any follow up. All consultations are either provided by a licensed clinical mental health professional or are reviewed by a licensed clinical mental health professional. If Clinicians are considering utilizing a locked inpatient psychiatric hospital, an on call Psychiatrist is contacted to review the intervention to be certain that the client meets criteria for Section 12. Philosophically, the team leadership and Clinicians in the field are committed to providing ready access to acute care services and the default intervention is one which happens in the community where the collateral providers deliver services and can contribute to the intervention in real time.

The team is also committed to meeting clients where they are at emotionally; when a crisis occurs, clients, providers and families can be stressed and the crisis intervention offers the client a safe space to talk through their experience and put a plan in place for crisis management. The team is committed to affect tolerance and provides high level risk management during the course of intervention. The team does not believe in hospitalization if it serves to make the provider or worried family member feel better. It must truly be the intervention of last resort. The BC mobile crisis team is comprised of staff who have language capacity including: Spanish, Haitian-Creole, Russian, French, American Sign Language (ASL), and Cantonese. Once a case is triaged the Clinical Manager can assign a Clinician to the intervention who would provide the best clinical fit for the intervention. Clinicians on the team have trauma-informed training and are trained around risk mitigation and use of natural resources.

3.3.2 Staff and/or Certified Peer Specialists: BMC plans to provide adult mobile services to the entire catchment area served under this proposal. Some mobile visits may require the assistance of a second staff person for several purposes: added support in situations where safety considerations could make a lone Clinician uneasy about providing outreach; assistance with cultural and language issues for which the second staff member has expertise; help with making phone calls to supports or coordinating access to diversionary treatment programs; and periods when the team is busy and a second person's assistance would facilitate moving the intervention forward in a timely way.

Similarly, the CPS and bachelor-level staff/master's level interns, perhaps credentialed with CPS, will be important team members in some mobiles to community sites, just as CPS staff will be integral players at the community-based location. Peer Specialists offer individuals in crisis and the clinical staff working with them another perspective on the process and potential ways to help stabilize the situation. Their training in the rehabilitation and recovery model will help cultivate a strengths approach during the intervention. BMC BEST has successfully integrated Peers into its current ESP and will seek to replicate this process in the subject catchment area. Additionally, the MBRLC is active in ongoing development of the CPS role for BEST, and its expertise includes being able to introduce the development of WRAPs with individuals seen by the crisis team. We will encourage our CPS staff to request permission of persons seen in crisis

to have follow-up for the purpose of creating a WRAP to help guide any future crisis interventions.

Our current ESPs have a robust system of training for master's-level students. For example, BEST BC CBL/Mobile Team had from September 2014 to August 31, 2015, a total of 12 interns: one for 12 months, seven for nine months and four for four months. Their weekly internship consisted of 16-20 hours, and interns trained on week day, evening and weekend shifts. These placements translated into four Full Time Employees (FTE). Students are invested in their training, and because of longstanding relationships we have with various field placement personnel, we request applicants who have experience in the field predating their master's programs or who can demonstrate the level of professionalism and poise required to do the challenging fieldwork. Prior to placement, students are interviewed by either the Program Director, Assistant Program Director or Team leader. They receive scheduled, weekly supervision from licensed supervisors. BC Mobile Team interns attend the agency's two-day orientation, the two-day PREVENT Training, and, if not currently certified, First Aid/CPR. They also attend a four-hour overall BEST orientation. In essence these social work and mental health counselor trainees carry out many tasks that meet and exceed the criteria of bachelor-level staffing. The program has welcomed students who are in recovery. We anticipate that the CCI-ESP will likewise develop a strong training program, bringing additional resources to the team and staff, likely in the amount of two FTE.

3.4 Adult Community Crisis Stabilization (CCS)

3.4.1 Program Description: V will provide a staff-secure, safe, and structured crisis stabilization and treatment service in a community-based location that serves as a medically necessary, less restrictive and voluntary alternative to inpatient psychiatric hospitalization. Admissions and discharges will occur 24/7/365. The CCS will be primarily used as a diversion from inpatient services. However, the service may be used as a transition from inpatient services when there is sufficient service capacity, and admission criteria are met. The CCS will serve adults ages 18 and older, including youth ages 18-21 under the CBHI. The CCS will serve up to seven adults at one time. This program will be co-located with the ESP and will work collaboratively with the ESP to develop short-term, effective interventions to help each client resume their everyday life and facilitate short length of stays. The CCS will provide nursing supports on each shift and have access to psychiatric support 24/7. While clients are in the CCS, further evaluations will be made by nursing and medical staff (MD/CNS/NP), including medication evaluation. Appropriate follow-up services will be initiated so that once the crisis for the client has passed; s/he will progress successfully to a less intensive level of care. A crisis/safety plan will then be created. Peer Specialist staff will help each client to create a WRAP when needed; these plans will be given to the client to take with him/her at discharge. Also, WRAPs will be entered into the client's electronic record so that they are available to ESP providers in future. The final essential function of the CCS team is to stabilize the client and coordinate follow-up services with Primary Providers, Therapists, day program staff and Psychiatrists in his/her community.

The primary service objectives of the CCS multi-disciplinary team are to:

- Restore functioning;
- Strengthen the resources and capacities of the client, family, and other natural supports;
- Support a timely return to a less restrictive community setting;
- Develop and/or strengthen the client's individualized risk reduction/safety plan; and
- Link the client to ongoing, medically necessary treatment and support services.

The flow of the service is as follows:

1. The CCS operates 24/7/365 for adults ages 18 and older. The CCS provides staff secure, safe and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive and voluntary placement.
2. The CCS services are short-term, providing 24-hour observation and supervision and daily re-evaluation and assessment of readiness for discharge.
3. The CCS provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services.
4. CCS services include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; mobilization of and coordination with family and other natural supports, community providers and resources; psycho-education, including information about recovery, rehabilitation, crisis self-management and how to access recovery and rehabilitation services available in the individual's specific community.
5. Individuals admitted to the CCS will have a community based disposition plan upon admission to the CCS.
6. The CCS will work closely with the ESP in order to enhance service continuity and fluidity between services.
7. The CCS will have a home-like, calm and comfortable environment that is conducive to recovery.

The CCS will be staffed by a lead RN, LPNs, Mental Health Workers and CPS. One RN will be designated as the lead/charge Nurse for the unit. S/he will receive support from the Nurse Manager of the BMC ESP. Medical coverage will be provided by a Clinical Nurse Specialist/Nurse Practitioner with MD backup, and treatment rounds that include the CNS/NP will occur daily. The CNS/NP/MD will meet with each client daily. Clients served by the CCS may have a range of psychiatric and behavioral symptoms yet cannot exhibit psychotic symptoms to the point of being disorganized or acutely/actively suicidal. Clients may have chronic medical conditions, but must be medically stable.

3.4.2 Physical Plant: The CCS will be configured in double bedrooms, with some limited single bedroom capacity. There will be kitchen space for the maintenance and preparation of snack food and meals. The space will include a lounge/living area and office space to provide for individual meetings with clients and to provide workspace for staff. A secure medication room will also be included.

3.4.2.1 Space: The site for the CCI CCS is centrally located in a commercially zoned area in Hyannis MA at 270 Communication Way. It is in a complex and mixed use industrial area, and has outdoor space and a large parking area. The ESP will be able to operate in this building with sufficient resources for staff, meetings and waiting areas. The current CCS has operated in this neighborhood successfully for over 15 years.

3.4.2.2 Strategies to Create Environment and Culture: Creating a positive interpersonal climate begins with our staff. Every employee of the ESP and CCS will be encouraged to focus on the following principles in their work with people in crisis: putting clients first, trust, teamwork, open communication, integrity, professionalism, flexibility, adaptability and accountability. Peer Specialists will be especially well-placed to offer support regarding the process of assessment and what to expect as matters unfold. As mentioned in the RFR itself, we have also found that small measures of comfort, such as snacks, refreshments, periodicals, music and other modest

amenities are important. We will use our experience in creating a cheerful, efficient and useful space in operating current CCS programs to continue the operation of this CCS.

3.4.3 Co-Location of the Adult CCS with the ESP Community-Based Location: The UCC walk-ins and the office space that serves as home to the Mobile Team will be located within the same building as the CCS. Thus, following the crisis evaluation, the staff may easily escort the client to the CCS for admission if indicated. The co-location will be in place at the point of implementation of the contract.

3.4.3.1 Co-Located CCS and ESP Space: Given the resources of BMC, BC and V, we anticipate the ability to identify and secure the appropriate space for the CCS and ESP program by the start date of the contract. The space will be used for the UCC, walk-ins and an office space that serves as home to the Mobile Team. Likewise, CCS staff will work closely with the ESP team for seamless communication about clients and program components. Our goals will be to provide adequate space for efficacy and comfort, and to allow all parties to work closely together collaboratively.

3.4.3.2 Co-Location Status at Implementation of ESP: Co-location shall be in place upon implementation of the ESP contract.

3.4.3.3 Not Co-Located at Implementation of ESP: Not applicable.

3.4.4 Recommendations and Rationale for Reallocation of CCS Capacity: Currently the CCS is providing services to 5-6 CCS clients and 2-3 DMH respite clients with a similar staffing pattern at any given time. Due to the current intensity of RN and MD resources to that unit, we are able to serve higher acuity clients, including those in need of detox, who are psychotic, have suicidal ideation and who have more active medical co-morbidities. We plan to negotiate with MBHP to increase the capacity from 6 beds to 7 beds due to an experience of an ability to manage a capacity of that level, as well as an assessment of need of the area based on past experience of the sub-contractor V. We will manage utilization by tracking and regularly reviewing average daily census and length of stay, as we currently do in all BMC ESP programs.

3.4.5 Communication Plan between Adult CCS and Other ESP Service Components: The weekly Clinical Leadership meetings described elsewhere in this proposal will include Managers of the UCC/Mobile Team and CCS, so that they are at the table with the Medical Director, the ESP Clinical Director, the QM/RM Director and other clients of Senior Leadership. The Managers will have a voice in overall decision-making for the ESP. Also, these Managers will meet weekly in Operations meetings for case review and utilization management review. There will be all-ESP staff meetings monthly where procedural issues will be discussed and trainings will be presented. On a daily basis, the ESP Clinical Director and UCC/CCS Managers will collaborate around staffing needs and volume flow so that resources may be shared and assigned accordingly.

3.4.6 Strategies to Shift Culture: We will draw on our experience in the existing BMC ESP programs and meet with potential referrers and agencies within the ESP area to educate them about the capabilities of the CCS. As they are able, we will encourage community providers to visit the CCS to observe the program design and services offered. We have found this to be helpful in our other ESP programs in order to create a level of confidence in the CCS's ability to manage clients who a referral source may have previously thought required inpatient hospitalization.

3.5 Mobile Crisis Intervention (MCI)

3.5.1 Statement of Intention: The ESP intends to enter into a subcontract arrangement with another entity that meets the requirements of subcontractors outlined in Section V.C. of this

RFR. Enter the name of the agency (additional information will be requested in narrative response section 4.3. below). The competency of the proposed subcontractor agency is demonstrated in the section that follows.

3.5.2 Rationale for 3.3.1 and Subcontractor Qualifications: BMC and BC have demonstrated a strong partnership and mutual commitment to the provision of quality MCI services as evidenced by the ongoing delivery of said services for the BEST. Since 2003, BMC and BC have collaborated to provide urgent, mobile and community-based responses to youth and their families experiencing behavioral health crisis. With the initiation of CBHI services in June 2009, those responses expanded to emphasize the Wraparound principles which inform the philosophy behind MCI services, and to include Family Partners in order to provide a bi-disciplinary team which is maximally responsive to family voice and choice. BC has also shown both flexibility and creativity in order to meet the rigorous standards of MCI, most notably with the creation of a Child Focused Team (CFT) within the larger Mobile Team, whose primary responsibility is to ensure that every family served has access to seven days of ongoing stabilization activities as needed.

3.5.3 Readiness to Provide Mobile Crisis Intervention

3.5.3.1 Behavioral Health Services to Children and Adolescents: As outlined above, BMC and BC have a demonstrated ability to provide behavioral health assessment and resolution focused interventions to youth and their families as the MCI provider for the Boston area since the outset of CBHI in 2009. During the previous fiscal year, the BCBEST team served 2,234 youth. These youth were each provided with an average of more than three days of ongoing stabilization activities by the MCI team, with up to 110 families receiving ongoing support and resolution focused care for up to seven days during the course of one month. BMC additionally oversees the provision of MCI services for the remaining communities in Suffolk County under the BEST contract, as well as the cities of Cambridge and Somerville for the CS-ESP—a combined 5,451 youth served in FY15.

BMC is also home to a robust outpatient Child and Adolescent Psychiatry clinic, serving over 4,500 youth annually under guiding principles which include care that is family-focused, culturally competent and prevention oriented. In operation since 1956, the ethnically-diverse, multidisciplinary team of child and adolescent Psychiatrists, child Psychologists and child-trained Social Workers provides specialized services including comprehensive assessment, advanced psychopharmacology, trauma-focused therapy, social-emotional skills-training groups, psychoeducational testing and parenting skills training.

Also since 1956, BMC Child and Adolescent Psychiatry has provided consultative services to primary care practitioners and hospitalists in the BMC Department of Pediatrics around the psychiatric assessment and management of physically ill or injured children. Through educational symposia, collaborative rounds and informal consultation, consulting child Psychiatrists also play a major role in increasing the capacity of primary care practitioners to deliver basic mental health services in the context of pediatric practices.

Since 1997, the BMC South Boston Collaborative Center has provided intensive outpatient substance abuse treatment services to youths in the South Boston community. The Center provides a broad range of outreach, prevention and treatment services in collaboration with its lengthy roster of community partners. Beginning in 2005, BMC Child and Adolescent Psychiatry also has provided consultation to Clinicians providing mental health services in school-based health clinics in Boston Public Schools high schools, and has placed child and adolescent Psychiatrists and Clinical Nurse Specialists in community health centers linked to BMC,

including Whittier Street Health Center, Dorchester House and South Boston Community Health Center.

In addition to providing MCI services through BEST, BC operates three community-based programs which provide a range of BHS and support to youth and their families: The Family Support Center, BC Academy and the Early Intervention Program. The Family Support Center provides both information and support to approximately 300 families per year who identify themselves as struggling with mental or behavioral health concerns. The culturally diverse staff at this center offer seven different service components for family members to participate in depending on their needs: information/referrals, trainings, support groups, parent networking, community connections/resources, and service navigation. Imbedded within the Family Support Center, and serving an additional 100 families per year, is the Parent Support Program (PSP). The PSP is staffed by parents and caretakers with lived experience navigating the behavioral health system on behalf of their loved ones, and in addition to the services offered at the Family Support Center, the PSP provides both online and in person parent groups, one-on-one support from a parent partner and educational advocacy.

BC Academy is a therapeutic school setting which served 27 students during the last academic year. BC Academy provides a high-intensity program that addresses the individual academic, social, behavioral and career development needs of its students. The entire school serves as a therapeutic milieu where students focus on individual emotional development, while at the same time completing a comprehensive academic program. Students are offered a comprehensive academic program, career development and transition services and individual and group therapy.

The BC Early Intervention (EI) program serves children under three years of age who are developmentally delayed, have a known disabling condition or are at risk of developmental delays due to biological or environmental factors. The program's goal is to promote the physical, mental and emotional development of eligible children. Services are provided in the children's homes, in the community and at the program site on Victory Road. Last year the Early Intervention program served 1,113 youth and their families across these settings. BC's EI program has been providing such services to children and their families for the past twenty years. Depending on the needs of the individual child, interventions can include:

- Multidisciplinary developmental assessments;
- In-home developmental play stimulation;
- Toddler developmental play groups, including transportation, if needed;
- Parent education and support groups;
- Individual or family therapy;
- Speech therapy, occupational therapy and physical therapy; and
- Service coordination and advocacy.

3.5.3.2 Knowledge, Commitment, and Experience Implementing Services to Children, Adolescents, and Families Consistent with Systems of Care (SOC) and Wraparound Principles:
As a current provider of MCI services to the Boston area, BC has a thorough knowledge of Wraparound principles, and over six years of experience providing services utilizing the System of Care philosophy as a guiding principle. BC staff, as well as clinical leadership from BMC, have attended trainings on the implementation of MCI beginning with the initial roll out of CHBI services in 2009, where an emphasis on care that is child-focused and family-driven was made from the outset. Since that time staff have continued to improve their fidelity to the Wraparound model with additional trainings on the Crisis Continuum, Resolution-Focused Interventions, and

the best practice utilization of the seven-day period following an initial evaluation. BC MCI providers have also received Technical Assistance trainings from consultant Kappy Madenwald on multiple occasions, most recently in June of this year. In practice, BC provides a bi-disciplinary response including a child-trained Clinician and Family Partner to youth and families in a variety of community-based settings including homes, schools, provider offices, community centers and an UCC which is available to families 24 hours a day. BC employs an ethnically and linguistically diverse staff, and interventions are delivered in a manner consistent with a family's individual cultural considerations. Under the supervision of the MCI Program Director at BMC, continual efforts to improve the quality of the services delivered are made, including the use of daily record reviews and in-the-moment consultation to staff providing MCI services.

3.5.3.3 Competence Working in Partnership with Youth, Parents, and Other Caregivers of Youth with Mental Health Needs: Recognizing the unique knowledge and contributions that Family Partners have made since being introduced to the provision of emergency services, the BC MCI team has shown a commitment to youth and families by continuing to increase the staffing level of this valuable position. Both BC mobile staff and the clinical leadership at BMC have observed the positive shift toward family-focused practice and the increase in shared decision making that occur when a caregiver's voice and choice are amplified by the MCI Family Partner. Family Partners have also proven to be an effective bridge to reaching families that might otherwise be reluctant to engage in MCI services, but who could benefit from additional support to maintain their youth in the community. For example, there have been numerous occasions where the BC MCI team has been contacted by a community based provider working with a family; the provider believes the family might benefit from MCI intervention, but they have been reluctant to engage due to lack of knowledge about the service, misperceptions about what it will entail, or both. In those circumstances a BC Family Partner has offered to meet with the family before an MCI intervention is ever requested in order to answer any questions a parent or caregiver may have, and to talk to them about the family-directed nature of MCI practice. When these meetings have occurred families have almost unanimously given the feedback that they would feel more comfortable in calling the MCI team than they had previously, and very frequently the outcome is a request for MCI intervention from the family themselves.

3.5.3.4 Policies, Procedures, and/or Clinical Protocols for Provision of Behavioral Health Services to Youth and Families: Please see Attachment 15: Child Focused Team Description which describes the composition and responsibilities of the CFT, a subset of the larger MCI team that carries out stabilization activities on days 2-7 of the MCI intervention; Attachment 16: Youth Consultation Protocol which outlines the consultation requirements for all evaluations of youth ages 0-20; Attachment 17: Youth Boarding Protocol which describes the clinical interventions and consultation requirements for youth boarding in the community for a 24 hour level of care; Attachment 18: MCI Hand off Protocol which outlines the procedure for the BMC ED to request ongoing clinical intervention for a youth being discharged from the ED, to be completed by the MCI team.

3.5.3.5 Outcomes Data, Quality Improvement Processes, Satisfaction Survey Instruments and Results Focused on Services for Youth and Families:

BC MCI Quality Indicators for FY 15

- Community Based Interventions Youth Ages 0-20 - 61.82%;
- Disposition-Inpatient Youth Ages 0-20 - 22.34%;
- Response Time in Minutes Youth Ages 0-20 - 35min; and

- Response Time % Within 60 minutes Youth Ages 0-20 - 82.53%.

Quality Indictors of MCI Service Tracked by BMC

- Documentation of best effort to reach parent/guardian prior to evaluation;
- Children/adolescents who are boarding evaluated every 24 hours after initial evaluation; and
- Increased use of youth boarding at home (vs in EDs) while awaiting CBAT placements, when deemed safe and with caregiver agreement.

As part of ongoing efforts to improve the quality of MCI services delivered to youth and families, the BMC MCI Program Director conducts daily reviews Monday-Friday of documented MCI service delivery by the BC Mobile Team within the preceding 24 hours. Feedback is given verbally and/or via e-mail to the BC MCI Team leader or CFT designee. Areas of review include:

- Quality and completeness of clinical information documented;
- Evidence of parent/guardian engagement and family-driven resolution; and
- Clear resolution focused goals for ongoing MCI involvement, if agreed upon by the family.

3.5.3.6 Training, Licensing, Certification, Accreditation, and/or Other Documented Verification of Expertise and Experience in Providing Behavioral Health Services to Children, Adolescents, and Their Families:

Child/Adolescent In-Service Trainings

- July 2015: *Community Practice Competencies: Higher Level Skills of a BEST Professional*, BEST Clinical Leadership staff
- December 2014: *Peer-Driven Recovery and Resources*, MBRLC, various staff
- March 2014: *The Art of Triage: A humanistic approach to case presentations for the Emergency Services Professional,* Hisla Bates, MD, Associate Medical Director, Massachusetts Behavioral Health Partnership
- January 2014: *Overview of Psychotropic Medications,* Catalina Melo, MD, Associate Director, BMC PES
- December 2013: *Separating the "T" from LGBT: Working with Transgender and Gender Non-Conforming Clients,* Chris Miller, BSW, MBA
- September 2013: *MCI in Action,* Tasha Kornell, LMHC, Youth MCI Program Director, BEST/CS-ESP

Child/Adolescent External Trainings

- May and June 2015: *MCI Technical Assistance Training*, Kappy Madenwald, LISW-S, Madenwald Consulting
- April 2015: *Advancing MCI Practice*, Kappy Madenwald, LISW-S, Madenwald Consulting
- April 2012: *MCI Model Enhancement Regional Forum*, MBHP staff
- January 2012: *Statewide CBHI Family Partner Forum: The Voice of Family Partners*, MBHP staff

3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention

BMC	BC
On-call Psychiatrist	MCI Team Leader
Director of Quality/Risk Management and Training	Child-trained Mobile Clinicians
Clinical Director	CFT Clinician
Assistant Clinical Director/MCI Program Director	Family Partner
	Child and Adolescent Trained Nurse Practitioner

3.5.3.7.1 Résumés: Current Staff Member(s) in Director-Level Positions and Above with Five Plus Years of Experience: Please see Attachment 19.
3.5.3.7.2 Job Descriptions MCI Team: Please see Attachment 20.
3.5.3.8 Experience Integrating Youth and Family Voice in Organization Governance: Individuals with lived experience including CPS and Family Partners assist both BMC and BC in integrating youth and family voices into our organizational governance. Membership at a weekly Operations Meeting, which brings together leadership from the various ESP components working under BMC, includes a CPS. Peer Specialists and Family Partners also serve a unique and valuable role in the training of new staff and Masters level internship students working for the BC Mobile Team. Ongoing efforts to highlight family and youth voice will also be made, including extending additional invitations to parents as well as transitional age youth to participate in formal Advisory Committee meetings.
3.5.3.9 Relationships with Child- and Family-Focused Community Resources in Service: As a provider of MCI services since the launch of CBHI in 2009, BMC—in collaboration with BC—has worked to build relationships with partners from across the System of Care in each community we serve, believing that these relationships are an essential component of improving access to high quality services and supports for youth and families. The foundation of these community relationships is to create opportunities to meet with consumers, schools, behavioral health providers and state agencies alike to discuss the individualized needs of each group. Leadership staff from BMC, as well as the MCI Team Leader from BC, participate regularly in multiple interagency forums where child and adolescent resources are the focus, most notably five monthly System of Care meetings that cover the various communities which comprise Boston. These SOC meetings are attended by staff from the host CSA as well as providers of other CBHI services, state agency staff from DCF, DMH, and DCF, staff from social service programs working directly with the community, and parents and caregivers of youth. The MCI leadership personnel from both agencies have also gained experience partnering with state agencies through a combination of regularly scheduled meetings, providing MCI related trainings to state staff, mutual participation on community advisory boards and crisis planning meetings to address the needs of specific individuals. One example of these partnerships is the School Based Mental Health Providers Collaborative, attended monthly by the MCI Program Director from BMC as well as the Assistant Director of Behavioral Health for the Boston Public Schools, the Director of Child and Adolescent Services for Metro Boston DMH, leadership staff from DCF and supervisory and director-level staff from multiple community-based mental health agencies providing services to youth within the Boston Public School system. In addition to creating a document outlining the standards of care for mental health provision in schools, this group has also worked to remedy service gaps for students in need of behavioral health treatment, as well as facilitating an annual day-long training for school-based mental health staff.

Relating specifically to agencies serving CCI, BMC and BC have an established working relationship with the Justice Resource Institute (JRI), which provides CSA services both to that region as well as the Roxbury area of Boston. The MCI Program Director at BMC has provided training on working with MCI services at CSA staff meetings, and is the regular contact for consultation on individual youth working with the CSA. These consultations have led to multiple instances of MCI staff participating in crisis planning meetings, attending discharge meetings and meeting with individual families who are new to BHS, in order to provide information about how MCI services can be utilized to help stabilize a youth in the community as needed.

BMC and BC staff also frequently work with all aspects of the Arbour Health System, which serves the Cape at its West Yarmouth location. BC mobile staff make numerous referrals annually to the Arbour system for youth and families requesting outpatient counseling and psychiatry care. BC staff also access the Arbour system's inpatient psychiatric units for children and adolescents requiring that level of care for stabilization before returning to the community.

Additionally, BMC and BC have an established working relationship with South Bay Mental Health, which provides outpatient BHS to the Cape at their Mashpee site, as well as both clinic and home-based therapy in the Boston area. BCMCI staff have made South Bay a frequent partner when referring for community-based services as agreed upon by the family served, with consistently positive feedback from parents and caregivers. BC staff have also attended trainings on special education provided by South Bay, and the MCI Program Director from BMC works regularly with various clinical leadership personnel from South Bay at both the School Based Mental Health Collaborative as well as System of Care meetings.

3.5.3.10 Membership in Child Advocacy and/or Child-Focused Trade Organizations: BMC, BC and V staff are members of the PPAL.

3.5.4 Mobile Crisis Intervention

3.5.4.1 Mobile Crisis Intervention Service and Bi-Disciplinary Intervention: Since 2009, BMC has been committed to the delivery of MCI services utilizing the Ten Principles of the Wrap-Around Process as a guiding philosophy. Throughout an intervention, family voice and choice play a central role in the provision of services, including the need for a culturally competent approach which addresses a family's preferences for setting, language, communication method and inclusion of natural supports. We prioritize providing MCI services in the least-restrictive community setting and on collaborating closely with the family's providers and supports of choice. Requests for MCI intervention will be received at a 24-hour 800# Call Center which will coordinate a response with the UCC located in the caller's community. As often as possible, a bi-disciplinary team including a youth-trained Clinician and Family Partner will be dispatched from the UCC to respond to the requested location, promoting the use of community-based settings whenever possible. The MCI team will gather information from the youth, parents and/or guardians and other collaterals as permitted by the guardians—including both formal providers and natural supports—to gain an understanding of the present crisis and the family's preferences for resolution. During the course of the intervention, the Family Partner will act with particular emphasis on supporting the parents or guardians in their experience of the crisis, as well as the MCI intervention itself, taking care to answer questions about the process and amplify the family's voice and choice. In consultation with appropriate team supervisors, a consensus agreement will be reached with the family regarding next steps to resolve the crisis, including referral to a range of formal and informal supports inclusive of 24hr inpatient care if indicated.

3.5.4.2 Managing Staff Resources to Meet Service Fluctuations in Intensity and Duration: In order to provide maximum flexibility, BMC plans to hire master's level Clinicians for the entire ESP who meets the MCI competency standards or who will acquire competency via ongoing training in the areas of expertise highlighted by the RFR (e.g., comprehension of grief and trauma in adolescents and children, risk assessment, and management skills in working with children, adolescents, and families). We will also seek to staff with primarily full-time employees, as opposed to part-time, to allow for fullest development of the program and to provide for consistently high quality interventions.

The ESP will use Family Partners and/or other youth-trained paraprofessionals to deliver MCI services in conjunction with Clinicians, and to help coordinate care with natural supports and

community-based providers. These staff will interface with families during initial evaluations, and will also be available for ongoing stabilization activities for up to seven days following the initial encounter depending on the volume and intensity of services needed by youth and families in the community.

3.5.4.3 Continued Intervention to Assure Coordination of Care Stabilization and Follow-Up Services: In order to meet the needs of youth and families for up to seven days of crisis stabilization support following an MCI encounter, BMC has developed a bi-disciplinary team of youth-trained Clinicians and Family Partners within the larger group of ESP Clinicians referred to as the CFT. The primary responsibility of CFT staff is to interface with youth and families subsequent to the initial encounter with MCI to develop an individualized and resolution-focused plan to determine which continued interventions will occur, if any. Each family that indicates a desire for continued intervention is assigned a CFT Clinician, Family Partner or both depending on their needs, who will remain the primary contact person throughout the course of the stabilization activities in order to maximize effective communication with the family. CFT staff will work with the youth, their caregivers and other system providers to ensure that the family's goals within the resolution of the crisis are met. During periods of high intensity and duration of MCI stabilization activities, CFT Clinicians and Family Partners maintain a primary focus on working with families for up to seven days following their initial encounter with MCI; when demand for these activities is lower, CFT Clinicians will become more available to conduct first-day evaluations and interventions with youth and families. CFT Clinicians will also become available to conduct initial adult face to face evaluations as needed.

3.5.5 Linkages with Other CBHI Services: BMC has a strong history of partnering with CBHI providers in its provision of MCI services, both during the course of urgent requests for evaluation, as well as building relationships with providers that encourage prevention and early intervention with families served. Attendance and active participation at the System of Care committee facilitated by the area CSA is an important building block for these relationships. It allows the MCI team to develop a strong alliance not just with the Intensive Care Coordinator (ICC) and Family Partner providers, but also with other partners who attend the SOC with the intention of improving the health and well-being of the families that make up the community. BMC has also made it a practice to reach out to providers of child BHS including IHT, TM and outpatient counseling, and to offer trainings to the staff of those services in collaborating with MCI to ensure the best care for their clients. With permission from parents or guardians, attendance at CPT meetings or other crisis planning meetings held by providers can also be a means to create positive relationships with both staff and families served, and can aid in the creation of a plan which emphasizes early intervention and least restrictive care.

3.6 Runaway Assistance Program (RAP): As a partner in the RAP, the CCI-ESP will make available 24-hour access to designated UCCs to allow police drop offs of runaway youth outside juvenile court hours "Non-Court Hours" being defined as hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically M-F, 4:30 p.m.-8:30 a.m. weekends and holidays. The goal of this program is to provide a temporary and safe place for youth to stay on a voluntary basis, until said youth is transferred to an Alternative Lock-Up Program (ALP) or other appropriate level of service. For the CCI area, the designated non-secure ALP is Community Care Services at 508-226-6031. The Manager is Tasha Ferguson, LMHC, Assistant Clinical Director and MCI Director.

We will employ the BEST RAP protocol which follows:

After determining that a parent/guardian cannot be located to take custody of the youth in question, police officers will initiate this process by contacting 211 and speaking with the "RAP Specialist," who will then do the following:

- Arrange a 4-way conference call between the requesting police officer/dispatcher, ESP Call Center, and a representative from the non-secure ALP;
- Provide the police with the name and address of the closest UCC;
- Request that a representative from the ALP proceed to the UCC where the youth will be dropped off in order to take custody and transfer the youth to the ALP; and
- Relay any known information about the youth to both the on-call RAP Clinician and the ALP, including name, DOB, last known residence, guardian's contact information, etc.

ESP responsibilities after notification by 211 of a RAP request:

Call Center

- Determine if Mobile Team staff is present on site at requested UCC—if present, notify that a RAP drop off will occur;
- If Mobile Team staff is not present, notify CCS staff at the appropriate site that a drop off will occur;
- Contact the on-call RAP Clinician to respond to the UCC; and
- Create a triage with any available information.

CCS

- Greet the police officer and youth upon arrival, and supervise the youth until the on-call RAP Clinician arrives. Of note, the youth is not permitted to be on the CCS unit at any time.

On-Call RAP Clinician

- Respond immediately to the UCC after notification from the Call Center;
- Conduct a brief evaluation of the youth and note any behavioral health or safety concerns to be relayed to the ALP staff upon arrival;
- If the youth is determined to require an acute psychiatric admission (i.e. inpatient or CBAT) attempt to facilitate admission, including contacting DCF hotline as needed if a parent/guardian is unable to be located;
- If not in need of an acute admission, continue supervising youth until pick up by ALP staff, or until the youth is transferred to another appropriate setting, i.e. guardian/DCF custody; and
- Complete documentation of assessment.

Youth will remain at the UCC on a voluntary basis until transfer to the ALP/other appropriate setting. If a youth leaves the UCC after drop off by police has occurred, the following steps will been taken if there is reason to believe the youth met Section 12 criteria during the brief assessment: contact the Psychiatrist On-call to complete Section 12 consultation process as usual. If the youth does not meet the criteria, the referring police department will be notified for the UCC if different from the referring department, the RAP Specialist will be notified at 211, and the ALP Program will be notified at 877-457-3210. Finally, emails with any details regarding the circumstances of the youth's departure will be sent to Tasha.Ferguson@bmc.org and an Incident Report will be submitted to MBHP on the next business day.

For on-call support contact Tasha Ferguson at 603-498-3093.

3.6.1. Experience Collaborating with Local Police Departments, Court Clinics and DCF Relative to Youth: BMC and BC have worked closely with the police departments serving our area—both at an administrative level and with individual area stations—to form mutually beneficial relationships that serve to increase access to appropriate supportive services for youth and families. Most notably, BMC employs two full-time Clinicians who co-respond with police

officers in Boston to provide on-scene assessment and intervention for youth and families with behavioral health concerns that come to police attention. The goal of these interventions is to divert individuals from legal involvement when connection with mental health services is the more appropriate response. In collaboration with BC, the BMC co-responding Clinicians can also directly facilitate connection to the MCI team for more intensive stabilization activities by transporting the youth and family to the BC UCC, or by requesting an MCI response to the family's home to continue the intervention in that setting. BMC has also provided informational trainings on MCI services to school police officers, as well as collaborating with multiple different police departments including the Massachusetts State Police to provide a RAP response as requested.

BMC also employs 2.5 full time equivalent Clinicians who work with individuals facing legal charges as members of the Criminal Justice Diversion team. This team works within three Mental Health Specialty Court sessions in the Boston area providing assessment, connection to services and case management support to transitional age youth and adults referred by the court due to ongoing behavioral health needs.

Both BMC and BC collaborate regularly with the DCF around youth and families in the areas we serve. Most frequently this comes in the form of requests for MCI intervention with youth engaged in DCF services—this includes youth residing at home with family, in foster care, at Stabilization, Assessment, and Rapid Reintegration (STARR) programs and at Caring Together residential or group home programs funded jointly by DCF and DMH. In addition to these urgent responses, BC MCI staff participate in DCF crisis planning meetings for youth in the community, as well as in ongoing care planning for youth in DCF custody who are boarding for psychiatric placement with the goal of stabilizing the youth who can then be maintained in the least restrictive setting. BMC leadership staff have also provided informational sessions and training for DCF staff regarding MCI services, and participate in a number of interagency forums with DCF supervisory staff including community System of Care meetings.

4. ADDITIONAL RESPONSE REQUIREMENTS

4.1 Hospitals as Bidders

4.1.1 Why BMC is in a Strong Position to Achieve Goals of the Procurement: BMC's commitment to community-based programs and accomplished leadership have demonstrated success with programs such as BEST, CS-ESP, MBRLC and SERLC. BMC is a founder and current partner of Boston HealthNet, a vertically integrated network comprised of 14 community health centers, BMC, and Boston University School of Medicine, and which serves Boston's underserved, diverse neighborhoods. BMC is the lead partner of BEST, partnering with two premier community-based behavioral health service providers in Greater Boston, North Suffolk Mental Health Association and BC. BMC is also the lead partner of CS-ESP, partnering with North Suffolk Mental Health Association and Cambridge Health Alliance. BMC has leveraged the knowledge and capability of the community-based providers in combination with its organizational leadership in administration, finance and medical/clinical services to create and implement a community-based ESP model that benefits adults and families in Boston. BMC has also led the development and implementation of successful ED diversion strategies. BMC's proposed CCI-ESP in partnership with BC and V—experienced and knowledgeable community-based ESP providers—will similarly establish a robust community-based ESP in the CCI area.

In the Southeast Area, BMC developed and has overseen the SERLC programs in conjunction with two capable community-based service providers, Brockton Area Multi-Services Incorporated (BAMSI) and V. As the lead agency for this important DMH-funded, peer-led recovery service, BMC has helped establish recovery service sites across the Southeast area. The Hyannis RCC is located at 45 Plant Road and is active five days per week. These programs will partner with the CCI-ESP to support persons in crisis. These programs will partner with the CCI-ESP to support persons in crisis.

4.2 Bidders Submitting Responses for Multiple Catchment Areas

4.2.1 Vision, Organization, Implementation and Staffing Plan: Strong partnerships with providers experienced in delivering community-based BHS for youth and adults and with deep community roots, trust, and knowledge are paramount to the delivery of high quality crisis services. BMC therefore proposes to partner with providers that possess these qualities and will provide them with a proven infrastructure necessary to support ESPs, including clinical and medical oversight, QM, financial management, an electronic web-based medical record system, and information technology support. Existing infrastructures such as on-call psychiatry, quality management systems, a call center, etc. would support well-staffed community-based urgent care and CCS sites along with enhanced mobile capacity in the CCI area. Strong collaborations with key stakeholders in the Southeast Area is critical to the efficacy of Southeast Area ESPs. BMC, BC, and V have well-established working relationships with many Southeast Area community-based providers and other stakeholders including, BAMSI, Child and Family Services, Growthways, Inc., DMH Southeast Area Office, JRI, NAMI MA, Cape Cod Healthcare - incorporates the Cape Cod Hospital in Hyannis and Falmouth Hospital, Duffy Healthcare Clinic-Hyannis which includes psychiatric and healthcare needs, Cape Psych Center-Hyannis, Cape Cod & Islands Community Mental Health Center-Pocasset), Crisis Intervention Services-Hyannis, South Bay Mental Health/Outpatient Services-Hyannis, Cape Cod Human Services-Hyannis, Cape Cod Human Services Fontaine Medical Center-Harwich, Cape Cod Free Clinic-Mashpee, Ellen Jones Community Dental Center-Harwich, Mid-Upper Cape Community Health Center-Hyannis, Medicine Store-Hyannis, Apothecare, VNA of Cape Cod, Hospice & Palliative

Care of Cape Cod, Cape Cod Community College, Department of DET, Career Opportunities (DET), Community Connections, Community Support. BMC also has a strong, effective working relationship with the DDS Regional Director, Rick O'Meara as well as the Area Director, Buddy Baker-Smith, and Site Director, Daniel Fisher of the DMH.

4.2.2 Strengths Realized by Serving Multiple Catchment Areas: We will realize economies of scale in more costly aspects of providing emergency services such as medical and clinical leadership, on-call systems, call center functions, information technology support, and QM Economies of scale allow the allocation of more resources to clinical services and staffing thereby meeting the ESP service needs of more individuals and families in the community. The new CCI-ESP will also benefit from BEST's and CS-ESP's intellectual capital, established recovery-oriented culture, community-based support, leadership and peer-inclusive infrastructure, expertise, and lessons learned. Additionally, existing and proposed partners from all four catchment areas will work collaboratively to support each other across catchment areas in times of high demand. Serving multiple areas across the Southeast also provides the opportunity to standardize communication, data collection, policy, procedure and practice which will enhance access and continuity of care for consumers across the Southeast Area. For example, utilization of a web-based EMR on a southeast area-wide basis allows access to client information even if a client is seeking crisis services in other than their own community.

4.3 Subcontracts

4.3.1 ESP

4.3.1.1 Subcontract Names and Rationale for Partnership: BMC plans to subcontract with two organizations in providing ESP services to the CCI-ESP communities.

BC was selected to be a subcontractor because it: 1) is a premier provider of community-based mental health and rehabilitation services for seriously mentally ill adults and children, those with intellectual and developmental disabilities, and persons with substance abuse problems in the Southeast, South Shore and Metro Boston areas; 2) has significant knowledge and expertise in the provision of ESP services as a BEST partner since 2004; 3) has a high degree of expertise in information technology and EMRs; and 4) has a proven track record of valuing consumer leadership and choice, peer support, and family-driven and youth-guided care.

V was selected to be a subcontractor because it: 1) is a premier provider of community-based mental health and rehabilitation services for seriously mentally ill adults, those with intellectual and developmental disabilities, and persons with brain injuries in the Southeast and Metro Boston areas; 2) has a proven track record of valuing consumer leadership and choice, peer support, and family-drive, youth-guided care as demonstrated while a BMC Psychiatry partner in the MBRLC since 2008 and in the SERLC since 2012; and 3) has expertise in the provision of ESP CCS services, as evidenced by currently operating the DMH CCI-ESP CCS in Hyannis and as a BEST CCS provider in the past.

4.3.1.2 ESP Service Components to Be Subcontracted with Each Agency: **BC,** in conjunction with BMC, will provide the CCI-ESP MCI adult mobile, and CBL services. In addition, BC will develop, implement and maintain/improve the information technology programs to support the CCI-ESP.

V, in conjunction with BMC, will provide the CCS services for the CCI-ESP.

4.3.1.3 Service Components and/or Populations Covered by Each Subcontractor: BC Services and V will provide their respective service components for the entire catchment area and population.

4.3.2 Management and Accountability of Subcontracted Providers: BMC has a successful track record in the development, implementation and oversight of the BEST program, the Boston ESP program which has three key partners: North Suffolk Mental Health Association, BC, and Massachusetts General Hospital Acute Psychiatry Services. A management structure similar to that of BEST, including Senior Leadership, Clinical Leadership, and Operations and Advisory Committees, will be developed to provide internal and external oversight and monitoring of service delivery, including administrative, financial, clinical, and quality. The Senior Leadership, comprised of the administrative and clinical leaders of the BMC DoP, will be fully accountable for the CCI-ESP and meet on a weekly basis to monitor the subcontracted services and will regularly participate in the other key committees as well.

4.3.3 How BMC Will Directly Provide the Majority of ESP Services: BMC, as the CCI-ESP contracted ESP provider, will provide a majority of the ESP services: 1) in conjunction with BC staff, will provide the CCI-ESP CBL, MCI, and adult mobile services; 2) Call Center/Triage 24/7/365 staff and functions; 3) all on-call child and adult psychiatry back-up services, telephone and face-to-face, and all direct psychiatry services for the CBL/CCS services; 4) complete financial oversight and claims processing services; 5) the majority of key leadership positions directly involved in the day-to-day operations, including CCI-ESP Director, MCI Program Manager, Medical Director, and QM Director; and 6) the support, expertise and guidance of the BMC Psychiatry ESP Senior Leadership Team.

Attachments

Narrative Response Attachments

ATTACHMENT 1: CONTINUUM OF CARE

Boston Medical Center

The ***Comprehensive Care Program*** in the Department of Pediatrics integrates primary care with specialty care and social services for children with neurodevelopmental and emotional/behavioral needs related to pre-term birth, congenital syndromes and chronic health conditions, and/or have experienced trauma as a result of abuse/neglect, parental abandonment, domestic violence, and parental substance abuse. Most of the children seen in the CCP have complex overlapping health, development and emotional/behavioral issues. Many low-income parents of special needs children tend to engage haphazardly and episodically with the healthcare system and fail to receive appropriate follow-up care and intervention. These parents often face economic hardships, educational barriers, psychosocial stigma, and social isolation as they try to cope with their children's needs and attempt to maintain stability for their families. The CCP, with its multidisciplinary approach, sees from 4 to 6 patients per hour, considerably less than the 8 patients per hour in a regular pediatric clinic. Additionally, during their primary care visit patients also can see a neurologist, pulmonologist, nutritionist, gastroenterologist, and/or a pediatric endocrinologist. This "one stop shopping" model of care promotes communication between all members of the child's healthcare team.

The ***Child Witness to Violence Project***, a nationally recognized, award-winning counseling, outreach and consultation program that focuses on young children who are exposed to domestic or community violence, providing trauma-focused counseling services to children and telephone consultations and referrals to agencies and individuals throughout Massachusetts, including the Department of Children and Families, the courts, other hospitals, neighborhood health centers, Head Start, and schools. The program provides a flexible combination of services, including resource advocacy to link families to basic services including health care, child care, housing, and after-school programs.

The ***Child Protection Team***, consisting of a pediatrician, nurse practitioner and social worker, files reports of suspected child abuse or neglect. The on-call consultation services are available 24/7 to BMC and Boston HealthNet providers.

The ***Elders Living at Home Program*** (ELAHP) helps older adults locate and maintain a permanent residence and allow them to live as independently as possible. ELAHP provides housing search, stabilization, nutrition, and homelessness prevention services. All of the elderly men and women placed in housing and provided housing stabilization services have remained successfully housed.

The ***Margaret M. Shea RN Adult Day Health Program***, licensed under MDPH, is a holistic medical intervention program that provides services in an ambulatory, home-like setting for adults who do not require 24-hour institutional care, but because of physical and/or mental impairment, are not completely able to live independently. Services include nursing, social services, activities, and transportation.

The ***Center for Infectious Diseases*** (CID) provides comprehensive HIV medical care and support services. Many patients experience mental health and substance abuse comorbidities, and approximately 30% utilize behavioral health services. Of these patients, approximately 58% have mood disorders, 80% are dually-diagnosed with substance abuse disorders, 60% meet the criteria for PTSD, and 24% of these patients have reported a history of intravenous drug use. In the CID one-stop-shop model of care, patients receive behavioral health services in the clinic and are referred to FAST Path (described below) for substance abuse treatment.

Facilitated Access to Substance Abuse Treatment with Prevention and Treatment of HIV (FAST Path) provides substance abuse and HIV risk reduction services within primary care settings at BMC for both HIV-infected patients and HIV-negative patients who engage in HIV risk behaviors. FAST Path targets racial/ethnic minority men and women whose alcohol or drug dependence places them at increased risk of transmitting (HIV-infected) or contracting (HIV-uninfected) HIV.

Project ASSERT, (Alcohol and Substance Abuse Services, Education, and Referral to Treatment), has been an ongoing component of safety net services at BMC's Emergency Department (ED) since 1998. During patients' initial point of service, Health Promotion Advocates offer "in-reach" services by consulting and collaborating with hospital staff to offer ED patients alcohol and drug screening, brief intervention, and referrals to health and social resources, such as substance abuse treatment and primary care services. By incorporating substance abuse services within the healthcare setting, Project ASSERT provides patients with comprehensive care in an emotionally supportive and non-judgmental manner. In December, 2014 Project ASSERT celebrated its 20th anniversary from its start as a demonstration grant with over 80 attendees including hospital staff, patients, community agency representatives, and government officials. To date, the Project ASSERT model has been replicated at hospitals throughout Massachusetts, including Addison Gilbert Hospital, Gloucester, Mercy Medical Hospital, Springfield, St. Anne's Hospital, Fall River, and South Shore Hospital,, Weymouth. In addition, it has been replicated at the MidMichigan Hospital System, Michigan.

The ***Boston Center for Refugee Health and Human Rights (BCRHHR)*** is a collaboration of the clinical and academic departments of BMC and Boston University Schools of Medicine, Public Health, Dentistry and Law; the National Center for PTSD; and Global Lawyers and Physicians. The multidisciplinary program provides comprehensive health care for refugees including primary care, behavioral health services, social services, and medical subspecialty referrals. BCRHHR also provides asylum evaluations, dental care, legal services, and a vocational rehabilitation program for survivors of torture and related trauma. In addition to clinical care, BCRHHR educates and trains agencies and professionals who serve these communities; advocates for the promotion of health and human rights; and conducts research.

Bay Cove Human Services

Bay Cove Human Services (BCHS) offers a comprehensive array of clinical mental health services that respond to the varying levels of consumers' needs including: eight Community Based Flexible Supports (CBFS) teams; one specialized outreach team, a Housing First program

(Home At Last); three Clubhouse programs; a Program for Assertive Community Treatment (PACT); Day Treatment; Tenancy Preservation Project (TPP); two specialized residences providing treatment for 12 men with mental illness and problematic sexual behaviors and a former Quarterway residence; 40 community residences with partial and 24 hour care; a Mental Health Clinic, providing psychopharmacology and therapy; a Department of Mental Health (DMH) transitional shelter, and four Community Crisis Stabilization (CCS) programs. BCHS also provides a full continuum of care for those receiving DD services and Child and Family Services including Early Intervention and a High School. Substance Abuse services include a Methadone Clinic with counseling and a 60 bed Transitional Support Services (TSS) program. Kit Clark Senior Services provides Adult Day Health, a Memory Loss Center, in-home services, and a senior drop in center.

PACT: PACT provides state-of-the-art treatment for individuals with mental illness who are unable to participate in traditional services, often because of severe cognitive challenges, discomfort in social situations, significant addiction to drugs and alcohol, homelessness, and court involvement. The PACT model is one of the most extensively researched options and is commonly regarded as the most "evidence-based" approach for community support of people with severe psychiatric disabilities.

The PACT model is empowering in its implementation because it offers clients only what they need, when they need it, usually at the setting where they live and in a manner that is most acceptable to them. In addition to more conventional mental health treatment, assistance is also provided in areas of housing, careers, meaningful relationships, symptom alleviation, and accessing medical care.

PACT provides its psychiatrist, nurses, therapists, and rehabilitation support staff with a manageable caseload so that they can provide needed services in a personalized and integrated way. The PACT model is uniquely responsive in that the team operates seven days a week and is available by telephone 24 hours a day. The level of contact can vary widely – from a single visit each week to several contacts per day during times of crisis. PACT clients are not required to visit the program offices for services. Instead, staff members often make visits to them at home, at work, in local coffee shops and other familiar community settings. Over 75% of services are provided outside of the office. In practice, this means that PACT may provide services such as daily medication delivery to a homeless client on the street, or regular supportive therapy while grocery shopping.

TPP: TPP assists individuals and families with mental illness, addiction disorders, or developmental disabilities who are at risk for possible eviction. This program prevents homelessness by helping these people stay in their current housing, or by helping them access more appropriate housing that better meets their needs.
TPP services are offered to Boston residents who come to the attention of the Boston Housing Court due to serious lease violations that jeopardize their tenancy. Approximately 200 hundred people comprise a routine "Thursday's docket" at the Boston Housing Court, and approximately 25% of these people are estimated to have significant disabilities that jeopardize their tenancy and put them at imminent risk of homelessness.

Represented in the population that comes to the Housing Court's attention weekly are Boston Housing Authority (BHA) residents, veterans, and female headed families. Participants range in ages from young parents with young children to elders. Income levels served include the very poor, who are eligible for transitional assistance from the state, and the working poor, who have very low paying jobs. Given the impact that permanent disabilities have on earning potential, most clients in this program fall in the very poor category (with annual earnings for a single adult estimated at under $7000 per annum). TPP services can mitigate the tragic consequences of eviction and ensuing homelessness for the majority of these people.

CBFS: CBFS are designed to help people with psychiatric disabilities thrive, and not just survive. The process begins with an appreciation of everyone's unique talents, hopes, and dreams. CBFS provides a comprehensive system of supports based on a close partnership between the person served and members of a flexible support team. These supports are continued throughout each person's recovery journey as they progress from structured and highly supported settings, to more independent and integrated ones.

For many people, the journey begins with housing in group homes and support in structured day programs, and then becomes increasingly less restrictive as the individual moves into independent apartments, attends school, or gets a job. However, each person's journey is different and the partnership with the flexible support team staff member helps tailor and coordinate services according to the individual's own values and aspirations. They receive the supports that best fit their needs and talents so that they can gradually regain control over their lives.

By identifying talents and ability, rather than focusing on disability, the CBFS team is able to support high aspirations. As people develop community connections and reestablish relationships with family and friends, they are able to use this growing "social capital" as a substitute for paid supports. Many are eventually able to graduate from services.

The flexible support team structure provides a variety of skilled resources, including peer specialists, nurses, and licensed mental health and substance abuse clinicians. BC's CBFS team serve 1100 adults living in downtown Boston, South End, Chinatown, South Boston, Dorchester, Roxbury, and Mattapan neighborhoods.

BCHS works in partnership with South End Community Health Center and Paul Sullivan Housing, a division of Pine Street Inn, in providing the following services:

- Nine Flexible Support Teams
  - Five by BCHS serving 506 people
  - Three by South End Community Health Center serving 294 people
  - One by Paul Sullivan Housing / Pine Street Inn serving 83 people
- The Unique Safety Net Outreach Team provides Enhanced Urgent Care to 217 people
- Staffed residences
  - 40 are operated by BCHS serving 430 people.
  - Eight are operated by Paul Sullivan Housing/Pine Street Inn serving 83 people

Safety Net Outreach: Some individuals with psychiatric disabilities do not engage in full CBFS services. These people generally prefer to live independently and to have full control over their daily lives. However, they are occasionally in need of short-term support during those times when they are experiencing acute distress or a crisis that requires staff intervention. Some of these individuals are homeless and also reluctant to engage in services or supports that assist them in securing housing.

BCHS has created a Safety Net that provides an innovative and cost effective method of meeting the critical needs of the approximately 200 people in the inner city area who have psychiatric disabilities but are living adequately on their own, and who are either unwilling to engage in services, or are only willing to utilize supports in an intermittent manner.
The Safety Net team includes a Program Director, a full time Peer Specialist, two Outreach Workers, a full time Employment Specialist and two Licensed Clinicians. This team provides a less intense level of case management to people who either need a lower level of support or who are not willing to engage in a recovery partnership, yet can benefit from a connecting relationship so that they are able to access services immediately in times of necessity.

The Safety Net Team helps people with concrete supports, such as securing benefits, providing representative payee arrangements, exploring and finding work, developing crisis plans, and helping those who are homeless access shelter and food. They work to facilitate connections with treatment, rehabilitative, health, legal, and recovery focused services to meet clients' needs. The Team tracks people with at least a once a month contact (face to face, by telephone, or through collateral contact), and maintains a record of each client's status. Though many clients utilize the team much more frequently, Safety Net Outreach offers support seven days a week so that if a client needs back up on a weekend they can readily access services.

The Michael J. Gill Wellness Center: The Michael J. Gill Wellness Center is born out of the CBFS holistic approach to recovery. It is a sad fact that the individuals served are dying on an average of 25 years earlier than other Americans. The Wellness Center has the vision to create opportunities for individuals to achieve the fullest of health and well-being. Groups are open to explore individual choices for lifestyle modifications in the areas of stress management, smoking cessation, physical activity, and nutrition. A peer-run healthy cooking group leads participants in the planning and cooking of a simple healthy meal. An evidence-based nutrition curriculum from the Center for Psychiatric Rehabilitation at Boston University will be offered twice yearly. Community acupuncture for clients is currently being offered at the Wellness Center to promote stress reduction, mood regulation, smoking cessation, and addiction recovery support. Other offerings include Yoga, Peer Recovery, and Substance Recovery groups. The Gill Wellness Center is currently growing and expecting to offer other services in the near future including Tai Chi, nutrition and diabetes education, and expressive therapies. It is open to clients served in the Fuller / BCHS CBFS Program and clients served throughout BCHS's other Mental Health Services.

Michale J. Gill Mental Health Clinic: BCHS assumed operations of the Michael J. Gill Mental Health Clinic in February of 2009. It serves many individuals in Jamaica Plain, Roslindale, Roxbury, and in the general Metro Boston area. The staff of psychiatrists, clinical nurse

specialists, and therapists provide a full range of diagnostic and behavioral health treatment services to adults (21 +), including psychopharmacological, counseling, and psychotherapy for individuals and groups. The clinic specializes in working with people with severe and persistent mental illness, dual-diagnosis, and other related psychiatric disorders. This behavioral health clinic works in close collaboration with the primary care clinic at Lemuel Shattuck Hospital andthe Goldfarb Ambulatory Care Center, and therefore ensures optimal integrated health care.

BEST: BEST is a 24-hour emergency services program for people requiring acute psychiatric intervention. Under the direction of BMC, BCHS is one of four providers who comprise the BEST service network (along with the BMC, Massachusetts General Hospital and North Suffolk Mental Health Association). BEST responds to well over 1,000 "calls" each month from a service area that spreads across metropolitan Boston, Brookline, Chelsea, Winthrop, and Revere, and includes seven hospitals, schools, detoxification programs, jails, community health centers and residences for people with mental illness. The demand for services has steadily increased, as the number of people seeking mental health services has grown.

Working with family members, human services providers, public safety and emergency personnel, and school administrators, BEST responds directly to the site of a crisis situation. The program goal is to keep people who are experiencing a psychiatric crisis out of the hospital by redirecting their care to community based programs like addiction services or family support services, where a successful outcome is more likely. Although hospitalization may often be viewed as the "gold standard," it is not necessarily the best treatment option. BCHS is a critical partner in the BEST operation as it provides crucial services including the Mobile Crisis Team and Urgent Care Center and a CCS unit.

CCS: The CCS unit is an unlocked crisis unit that helps people in an acute behavioral health crisis to stabilize, strengthen their coping resources and supports, and develop a plan to live a better life. CCS offers rehabilitative and recovery focused services that enable people to get through such crises without needing to rely on more costly and unnecessarily restrictive inpatient psychiatric services. As a critical component of the BEST, CCS is operated by BCHS and BMC and offers state of the art diversionary care and provides:

- Psychiatric evaluation and assessment
- Medical, psychiatric, and addiction treatment (including detoxification)
- Psychopharmacology assessment and treatment
- Peer-to-peer support through the Boston Resource Center
- A safe, structured environment
- Education about behavioral health concerns
- Step-down from inpatient treatment
- Referrals to psychiatric and addiction services outpatient treatment, health, social services, etc.
- Coordination and collaboration with treatment providers

House Day Treatment: This adult psychiatric day treatment program offers a variety of specialized groups in a supportive community. These groups provide structure within which to address each consumer's individual, clinical rehabilitation needs. The program is designed for

consumers who are either transitioning from higher level of care (e.g. inpatient hospitalization) or would benefit from additional support and structure to prevent the need for such a level of care. The program works well for people with a wide range of diagnoses and treatment needs. Each consumer participates in individualized treatment and specialized groups, including groups for:

- Dual Diagnosis
- Dialectical Behavior Therapy (DBT) Skills
- Post-Traumatic Stress Disorder (PTSD) / Trauma Survivor Support
- Independent Living Skills

BCHS Day Treatment operates with the philosophy of achievable mental health recovery and offers groups facilitated by consumers of mental health services. The goal of the program is to help consumers transition to less treatment-intensive settings as they are ready. These include educational/ vocational programs, clubhouses, and volunteer settings. Sample activities include sobriety check-in, mental health recovery, goal planning, yoga, expressive therapies, symptom awareness, fitness, and bereavement counseling.

Clubhouses: Transitions of Boston and Center Club Boston are clubhouses for adults with psychiatric disabilities, dedicated to the principles of self-help, peer support, and empowerment. The Clubs offer a safe and supportive environment in which members of the program can work towards building meaningful lives, connecting to the larger community, assuming valued roles in the communities of their choice, and ultimately living as independently as possible. The services provided by the Clubs are individualized and based on each member's needs, strengths, and choices, which are assessed at the time a person joins the program. Each member participates in individualized goal planning with their key staff member at the Club.

Vinfen

CBFS Programs: Since July 2009, Vinfen (V) has been the largest provider of CBFS services for the DMH in the state of Massachusetts. All of V's CBFS services are standardized and based on the evidenced- based practices of Assertive Community Treatment (ACT) and the Individualized Placement and Support Model of supported employment. V operates 18 Collaborative Action for Recovery (CAR) Teams within eight CBFS contracts with DMH. These DMH Sites are Cape Cod and Islands, Plymouth, Metro Suburban, Mass Mental, Cambridge Somerville, Essex North A, Essex North B, and Lowell. The model provides four interlocking components: Collaborative CAR Team(s), Operations Support (includes housing specialty staff), Congregate Settings, and Organizational Support. The CBFS model is a system in which the CAR team and the congregate sites function as one integrated component.

CCS Program: In March of 2012 V was asked to assume the operation of the Cape and Islands CCS program. This program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community based location that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older; including youth ages 18-21 under the Children's Behavioral Health Initiative (CBHI). This program currently has capacity to serve 10 adults any given time. The 10

beds include six CCS beds and four DMH respite beds. The CCS Program works closely with the DMH ESP to develop short term, effective interventions that will assist the individual client in resuming their everyday life. In addition, the CCS team provides nursing on each shift and has access to psychiatric support through the Cape Cod & Islands Community Mental Health Center 24 hours a day. These medical personnel are primary service providers at this program. One of the major functions of the CCS team is to stabilize the individual client and coordinate follow-up services with Primary Care Providers, therapists, day program staff, and psychiatrists in the community.

Program for Assertive Community Treatment (PACT): Since February 2003, V has operated a PACT Team for 80 clients in DMH's Essex North Site; and since July 2007, a team for 80 clients in the Cape Cod & Islands Site. The staff provide support and services in a collaborative effort with clients in a variety of community settings. The PACT program has recruited and hired qualified staff from diverse backgrounds, produced positive outcomes with clients who have the highest challenges/needs, and successfully operated the programs according to DMH and National ACT Standards cited in *"A Manual for ACT Start-Up" (Allness and Knoedler, 2003).* By establishing a trusting and mutually respectful relationship with clients, PACT staff have engaged clients, many of whom had previously refused services of any kind. PACT staff have also helped clients secure part-time or full-time employment, dramatically reduced their use of psychiatric hospitals and emergency services, helped formerly chronically homeless clients secure and maintain housing for the first time in their lives, and collaborated with clients to establish or re-establish meaningful social supports that bring joy and hope to their lives.

Young Adult Services: An emerging priority population for the DMH is Transition Age Youth (TAY) and young adults. V was awarded a contract to provide an evidence-informed practice to TAY called Transition to Independence Process (TIP) in 2005. TIP, a research supported model of support serving an emerging population of TAY, is a strength-based process of working with young people. V began serving this population in the early 1990's and designed supported housing specifically for these young people to avoid group home placement whenever possible.

Clinical Services: V provides a wide range of clinical services to thousands of DMH clients each year. A full range of outpatient services are offered through People Care Clinic, the licensed outpatient clinic, a not-for-profit subsidiary of V for nearly 26 years. Small and specialized, the People Care Clinic serves clients with complex conditions, including Co-Occurring Disorders (COD), and Borderline Personality Disorder.

Psychosocial Rehabilitation: More than 1575 DMH clients a year attend V's seven Clubhouse programs. V also operates six residentially-based day programs. The programs are focused on skills and residents' mutual support.

Recovery and Other Peer Initiatives: In 1993, V was the first provider in the state to hire a Director of Recovery. The Director of Recovery is a member of V's senior management team and has a lived experience of mental illness. V's Director of Recovery, Lisa Halpern, provides guidance on policies and practices, works directly with staff and clients, and offers her valued perspective in staff training and as a teacher. V operates Recovery Learning Community

services, through a subcontract with Metro Boston Recovery Learning Communities, in Somerville, Plymouth, Hyannis, Fall River, and New Bedford.

Family Initiatives: For the past 16 years, V has hosted and coordinated National Alliance on Mental Illness (NAMI) Family to Family groups in several service areas. The NEA's TIP project has benefited from the successful family engagement models designed by Dr. Rusty Clark, developer of the TIP model. TIP offers practical approaches for family members on setting reasonable expectations for their loved one, the recovery and relapse processes, collaborative family problem-solving, and long-term planning.

Developmental Services Division: V offers a comprehensive array of services for individuals with intellectual and developmental disabilities, autism, visual and hearing impairments, and physical disabilities. The Developmental Services Division partners with individuals, their families, employers, and communities, to help them receive the services they need to achieve their goals and attain independence. V supports nearly 1,000 individuals in 80 service settings in Massachusetts.

Brain Injury Services: V provides a variety of services for people with acquired or traumatic brain injury, and partners with individuals, their families, providers, and communities, to assist the individual in receiving the services that will help them accomplish their goals. Integrated into V's Brain Injury services are the latest developments in clinical and rehabilitation intervention, including cognitive, behavioral, and computer-assisted technologies delivered by caring and highly trained staff.

BOSTON MEDICAL

ATTACHMENT 2

BMC ESP Quality Management Plan

Quality Management Philosophy

The BMC ESP Program is committed to a program-wide plan for Performance and Quality Improvement that focuses on improving the important functions and processes of the Program in order to

- Improve the quality of care and patient outcomes
- Enhance the value of all services provided
- Improve the Program's operational efficiency

The definition, measuring, monitoring and improvement of quality service are the responsibility not only of the Quality Management Director and QM Committee, but also of every person in the ESP Program.

We believe that there is always room for improvement in all processes, systems and services and reject the adage, "If it's not broken, don't fix it".

Decisions are based not on whim or intuition, but rather on the consideration of facts and data.

When a problem is identified, we will not jump to a solution. Instead, we will define the problem clearly; collect data to better understand the extent of the problem, its causes, and the contributing factors; based on the analysis of the data, develop a possible solution, implement it and go back later to monitor its effectiveness in solving the problem. This approach has a greater likelihood of solving the problem permanently, rather than being a "quick fix", and it can be done in a timely manner.

When we encounter a conflict or thorny issue, or when we receive a complaint, we will talk about these openly and with detail. Most often these issues are the result of a flaw in one of our systems, not the result of incompetence by an individual. Therefore, the frank discussion of issues must be viewed not as finger pointing and blame-placing, but as an opportunity to fix the system and allow the people within it to succeed.

The BEST Quality Management Program includes a focus on both Quality Assurance and Quality Improvement:
Quality Improvement examines existing work methods, processes and systems and develops ways to make them better. It is not necessarily problem-based, but rather assumes that there are always opportunities for improvement.
Quality Assurance looks to answer the question: what do you do and how do you know you're doing it well? (i.e. assuring quality)
Therefore, each component of the ESP considers:

- What do you define as your most important aspect(s) of work? What are the most important things that you do? Why are you here?
- How do you know that you're doing those things well/right? What objective data or information do you look at that tells you that?
- How do you collect that data? How often do you examine it? What performance standard (percentage or numeric threshold) have you set for your service?

In addition to each component of the service creating indicators of quality, the ESP program as a whole identifies its aspects of work which are high risk, high volume, or problematic. Quality Assurance and Quality Improvement activities and teams may be organized to address these issues; also, such issues may be referred to existing committees for exploration and problem solving.

Purpose and Goals of the Quality Management Plan

The Quality Management Plan provides a framework for a systematic, comprehensive approach to planning, measuring, analyzing, and sustaining improved performance of BMC ESP program-wide systems and processes; it supports the ESP mission of providing comprehensive emergency behavioral health services for the defined service area.

The goals of the QM Program and Plan include:

- To provide mechanisms for the identification, assessment, maintenance, and improvement of organizational performance and patient care/treatment outcomes for person served by the ESP.
- To ensure timely and practical resolution of identified problems or issues using the quality management process and principles.
- To ensure that valid and reliable data are gathered, reviewed, analyzed and utilized in the identification and resolution of problems and improvement in quality of services.
- To identify and prioritize system issues that impact the quality of patient care and of the patient's experience.
- To establish an organization-wide forum in which to pursue all identified opportunities to improve the service provided by the ESP.
- To ensure that the services provided by the ESP meet all standards and regulations set by:
    1. Department of Public Health
    2. Department of Mental Health
    3. Affiliated Managed Care Organizations
    4. Massachusetts General Laws and Regulations
    5. All other relevant licensing, accrediting or certifying bodies

Structure of the Program

Senior Management Team consists of the Department's Vice Chair for Clinical Services, ESP Medical Director, the Director of Clinical Operations for the BMC Department of Psychiatry, the Clinical Director of the ESP, and the Director of Quality/Risk Management. It functions as the executive group for the ESP program. Among its functions is the oversight of the Quality Management Program, including the prioritization of Quality/Improvement activities; initiating, overseeing and coordinating PI activities, and receiving reports and approving recommendations from PI teams

ESP Operation Group includes the ESP Medical Director, the Director of Clinical Operations for BMC Department of Psychiatry, the ESP Clinical Director, the Director of Quality/Risk Management, the Medical Directors of Psych Emergency Services from BMC and partner designated EDs, and the Managers of the UCCs. It meets weekly. This same group also comprises the **Quality Management Committee** and meets monthly in that capacity. Its functions include:

- Establish expectations and performance standards for all components of the ESP program

- Reviews volume, activity and utilization data to identify high-user clients, diversionary and hospitalization rates, barriers to accessing service, community services with high/low utilization of the ESP
- Identify opportunities for improvement based on this and other data; make recommendations to Senior Management Team regarding QI/PI activities
- Manage the PI process; ensure the implementation of processes to measure, assess and improve performance
- Resolution of problems and complaints that could adversely affect the delivery of services
- Stakeholder survey; review results and identify target areas for improvement

Advisory Committee meets bimonthly and consists of a representative group of internal and external stakeholders, e.g. the area's School Department, Police Department, Court Clinic, consumers mental health services, homeless shelters and services, DMH, DMR, DSS, DYS, etc. Issues raised by this group inform the work of the Quality Management Committee. There are separate Advisory Committees for each BMS-led ESP (BEST and Cambridge/Somerville).

The Director of Quality Management is responsible for the development and oversight of a fully integrated performance improvement/ quality management plan, which ensures the quality, appropriateness and continual improvement of services provided by the ESP program. This position supports the quality/performance work of the ESP and coordinates the activities of the aforementioned groups and chairs the Quality Management Committee. (S)he also provides Quality Improvement education and information to all components of the ESP.

Data collection and Measurement

Data collection is key in translating information into opportunities for improvement by quantifying a situation, tracking a process, identifying gaps ion performance, and in verifying whether the objectives of various improvement strategies have been met. Objective data allows us to make the best possible decisions regarding the delivery of quality services to our patients and other stakeholders.
Sources of data include:

- Weekly and monthly Activity Reports which include data on encounters by team and ED, hospitalization and diversion rates, types of services and levels of care to which patients were referred (dispositions), CSU utilization (admissions, discharges, average daily census, average length of stay, declined admissions)
- Encounter and clinical documentation on patients is website based. This allows for flexible queries and reports on a variety of metrics, including response time of teams, volume trending, demographic attributes of patients served, etc.
- Risk Management findings (e.g. incident reports, complaints)
- Internal and external customer needs and expectations
- Stakeholder and consumer satisfaction surveys
- Medical record review for quality, timeliness, appropriateness of documentation
- Case reviews to identify patterns of utilization, barriers to service, treatment outcomes, and the development of system-wide crisis plan for the patient

Methodology

On small scale, leaders of teams identify opportunities for improvement in daily work and use the PDCA cycle of QI:

- What am I trying to improve? (to define the problem)

- How will I know if my change is an improvement? (to pick the right metric)
- What change can we make?
- Then plans the change (**P**lan); carries it out on a small scale (**D**o); checks the results (**C**heck); extends the change to the whole operation with modifications as necessary (**A**ct)

When confronting larger scale issues that cross components and involve a task group or PI team, we use the FOCUS/PDCA method:

F= find an opportunity to improve

O= organize a team that knows the aspects of the existing problems; define the problem and write a problem statement

C= clarify the current process to all team members; define desired outcome and what information is needed to understand the problem, its root causes and possible solutions

U= understand the sources of variation in the process being studies; collect and analyze pertinent data

S= select the improvement action from the ones that may have been identified

Prior to implementing a new program or process, we conduct a FMEA (**F**ailure **M**odes and **E**ffects **A**nalysis). This analysis is conducted by a team consisting of the primary stakeholders of the new process/program. The team identifies all the steps involved in the proposed process/program that could fail or go wrong. Each of possible "failure modes" is assigned a numerical value, that indicates its criticality in terms of how severe it is, how detectable it would be and the probability of its happening. This process prioritizes where the team should turn its attention first. The team identifies causes and potential fixes for each of the failure modes, so that intervention can be made before the process/program is implemented. It is prospective and preventative, versus traditional approaches of analyzing events after they occur.

Annual Evaluation

The Quality Management Committee evaluates the QM Plan annually, reviewing its effectiveness in achieving the goal of assuring that the most appropriate quality of care was provided to patients. Also, the Committee:

- Reviews the annual summary report of the past year's QI/PI activities, improvements made, care delivery processes modified, and projects in process
- Defines performance indicators for the next year and numerical/percentage thresholds for each
- Identifies additional data which should be collected to demonstrate performance, the frequency of data collection and analysis,
- Makes recommendations for change to the QM plan

All findings and recommendations are sent to the Senior Management team for review and approval.

Examples of Quality/ Performance Indicators by service

Call Center

- Incidence of neither mobile team being available for an evaluation in a non-designated ED within 1 hr
- Incidence of neither mobile team being available to a community-based site within 1 hr, resulting in client being sent to an ED

Designated EDs

- Wait time to be seen by psychiatry
- Youth cases handed off the ESP following ED contact/evaluation
- Hospitalization rate
- Referrals to CSU
- Referrals to other diversionary services
- Contact with collateral treaters/ PCP

UCC Mobile teams

- Response time from when request received to when clinician begins evaluation
- Hospitalization rate
- Referrals to CSU
- Referrals to other diversionary services
- Community-based evaluation by site (residential, home, school)
- Contact with collateral treaters/PCP
- Documentation of best effort to reach parent/guardian prior to evaluation
- Children/adolescents who are boarding evaluated every 24 hours after initial evaluation

UCC Walk-in

- Client wait time to receive psychopharmacology appointment
- Contact with collateral treaters/PCP

CCS

- Rate of patients being stepped up to hospital level of care
- Contact with collateral treaters/PCP
- Follow-up appointment with treater/program scheduled to occur within 5 days

Other

- Indicators based on results of the Stakeholder Satisfaction Survey
- Evaluation of program by every member and level of the ESP, using the 360 degree method
- Focus groups of clients through RLC regarding satisfaction with services, service needs and gaps
- Stakeholder surveys through Advisory Committee
- Case reviews in Operations meeting and in Kids Services meetings
- Patient satisfaction surveys in CSU
- Sampling review of patient records by QM Director to monitor quality of documentation and appropriateness of assessment and decision-making

Examples of recent QI activities and improvements

- Implementation of Docusign system whereby backup psychiatrists can use phone or tablet to complete and sign Sect. 12 forms for clinicians in the field, following consultation with clinician. Allows document maintenance and storage as well as more timely response to request.

- Institution of monthly all-ESP trainings. Recent topics include MI/PSB; patient presenting with intoxication and SI; child sex trafficking; motivational interviewing; impact of racism on provision of MH services.
- Creation of Community Outreach Clinician in Cambridge/Somerville to analyze community demographics and services utilization to assist with targeted outreach efforts, increase ESP utilization and decrease ED utilization
- Refined handoff processes shift-to-shift within programs, and day-to-day between program components
- Increased presences of Recovery Learning Community staff in CCSs
- Medication education for RN staff in CCSs
- Increased use of youth boarding at home (vs in EDs) while awaiting CBAT placements, when deemed safe and with caregiver agreement
- Increased number of Mental Health Court sessions and number of clinicians in those courts
- Participated in MBHP-sponsored CQI consumer satisfaction effort
- Conducted a survey of BMC and MGH EDs regarding reasons patients choose EDs for care

BMC ESP Data Management Grid

Type of Report	Who's the Audience	How to Use the Information	Frequency of Reporting	Responsible Person
Response time to non-designated EDs	ESP Operations group; Senior Leadership	Identify/analyze trends and the variables which may impeded and/or facilitate response time) especially those greater than 1 hour from time patient is ready	Quarterly	Dir. QM
CCS patient satisfaction	CCS staff; BEST Senior Leadership	Identify areas of the program with which patients are/aren't satisfied; create QI action plans to improve the areas identified as in need of same	Quarterly	CCS Program Managers
Psychopharm utilization by both UCCs	Senior Leadership;	Examine patterns/trends of utilization (volume vs. capacity, no shows, initial and follow-up appointments	Monthly	ESP Clinical Dir.
Calls to Call Center which did not lead to an evaluation	Senior Leadership;	Identify volume of calls; sources of, reasons for and appropriateness of calls. Risk Management purposes	Quarterly	Call Center Dir.
Monthly Activity and utilization Reports	ESP Operations group; Senior Leadership; Advisory Committee	Describes all aspects of activity in all components of ESPs (volume, location, disposition, hospitalization rates, etc.). Allows analysis of utilization and other aspects of compliance with ESP standards	Monthly	ESP Clinical Dir.
Incident report and complaints tracking	Senior Leadership; ESP Operations group	Identify serious incidents which require immediate change in policy/procedure/process. Analyze trends to identify opportunities for improvement	Quarterly	Dir. QM
Patients boarding in EDs	ESP Operations group; Senior Leadership	Monitor volume of boarders; analyze reasons for same, with a goal of making systemic changes to decrease boarding rate	Monthly	ESP Clinical Dir.
High users of ESP services	ESP Operations group;	Identifies clients seen more than twice in a month so that Crisis Plans may be created and attempts may be made to hook client up with ongoing treatment	Monthly	UCC managers
CCS utilization	Senior Leadership; ESP Operations group	Analyze volume, LOS, trends of issues dealt with, post-discharge treatment and follow-up; allows future program modification and improvement	Monthly	CCS Nurse Mgr

CCS unplanned discharges	Senior Leadership; CCS Leadership	Analyzes reasons patients leave the CCS prematurely; facilitates program improvements to decrease unplanned discharges	Quarterly	CCS Nurse Mgr
Use of diversionary services	ESP Operations group; Senior Leadership	Look at the degree to which each team is using CSU, Detox, EATS, ART, PHP, FST diversionary services	Monthly	ESP Clinical Dir.
Results of client and stakeholder satisfaction surveys	ESP Operations group; Senior Leadership; Advisory Committee	Identify areas of satisfaction and dissatisfaction with services; informs planning and decision-making for quality improvement activities	Annually	Dir. QM
Clinician profiles	Senior Leadership; UCC managers	Looks at number of encounters done by each clinician and use of diversionary services (vs. hospitalization). Sample of each clinician's case write-ups are also reviewed, for quality of assessment and documentation. Informs clinical supervision by team managers	Semiannually	Dir. QM

ATTACHMENT 3: ESP RESPONSE TIME

BEST/
Cambridge Somerville ESP
Information System
Give Us Feedback
Give me 20 more minutes

ESP RESPONSE TIME

Back to Main Menu
(Help Desk 617.371.3039)

Click Here to Log Out

Resource Directory
PsychoPharm Calendar

Start Date: 07/01/2015 End Date: 07/31/2015 Submit With New Dates

07/01/2015 through 07/31/2015

How do I read this report?

ClientID	Team	Date/Time Eval Began	Shift	Location/Date/Time of Readiness	Response Time	Readiness Time
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/01/15 06:00PM 07/01/15 07:00PM	E	At Home 07/01/15 06:30PM	1 hrs	0.5 hrs
[redacted]	BEST-BMC 800 CS ESP North Suffolk UCC	07/04/15 10:15AM 07/04/15 11:00AM	D	At Home 07/04/15 10:15AM	0.75 hrs	0.75 hrs
[redacted]	BEST-BMC 800 CS ESP North Suffolk UCC	07/07/15 02:30PM 07/07/15 03:30PM	D	At Home 07/07/15 03:30PM	1 hrs	0 hrs
[redacted]	BEST-BMC 800 CS ESP North Suffolk UCC	07/17/15 11:15AM 07/17/15 02:00PM	D	At Home 07/17/15 01:00PM	2.75 hrs	1 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/13/15 03:00PM 07/13/15 04:15PM	E	At Home 07/13/15 03:45PM	1.25 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/17/15 12:30PM 07/17/15 02:00PM	D	At Home 07/17/15 12:30PM	1.5 hrs	1.5 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/29/15 12:15PM 07/29/15 04:45PM	D	At Home 07/29/15 04:30PM	4.5 hrs	0.25 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/14/15 03:15PM 07/14/15 05:00PM	E	At Home 07/14/15 04:00PM	1.75 hrs	1 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/14/15 02:45PM 07/14/15 03:45PM	D	At Home 07/14/15 03:15PM	1 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/10/15 11:00AM 07/10/15 12:00PM	D	At Home 07/10/15 11:30AM	1 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/15/15 11:45AM 07/15/15 01:00PM	D	At Home 07/15/15 12:00PM	1.25 hrs	1 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/28/15 12:15PM 07/28/15 01:00PM	D	At Home 07/28/15 12:30PM	0.75 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/30/15 09:45AM 07/30/15 11:30AM	D	At Home 07/30/15 11:00AM	1.75 hrs	0.5 hrs

ATTACHMENT 4

When and How to Request a Crisis Evaluation

Reasons to Call

- **To help determine whether the person is safe**
- **To access additional treatment**
- **To consult on what to do**

Remember: Follow your agency's crisis protocols which may include consultation with your supervisor or admin on-call

Call

1-800-981-HELP

(4357)

1 Provide your information & client's demographics

- Your Name
- Role/Relationship to Client
- Direct phone number
- **After hours or alternate contact number**
- Client's Name
- Client's Date of birth (DOB)
- Client's Social Security Number
- Client's Insurance information
- Client's Address & phone number
- Location where client will be seen
- Provider/Outpatient clinicians' names/numbers
- Any crisis plan that may exist for client

2 Describe the person's concerning behavior:

- Give specific examples of how the client is acting, e.g., making suicidal statements, stating others are out to harm him or her, staying up all night talking to people who aren't there
- Describe whether the client is cooperative and willing to be engaged VS. uncooperative or unaware that the ESP is being contacted
- Any known history of the client's behavior in similar situations to help understand risk

3 Safety & Risk Assessment (sample questions)

- Who is in the home/ residence with client?
- Who can be present to introduce ESP staff to the client? (Required if client does not know that the ESP is coming or is not agreeing to the visit)
- How are persons in the home/residence related to client?
- Anyone in the home who is actively using substances?
- Anyone in the home who is agitated, threatening or otherwise violent?

4 Possible outcomes:

The Call Center will help decide whether to …

a. send a **mobile clinician** to the client
b. have the client come to our **urgent care site;** or
c. whether a Section 12A to an emergency department must be considered.

STOP Call 9-1-1

For **IMMEDIATE DANGER**—call 911 in lieu of ESP (Overdose, Bleeding, Violence, Life-threatening substance intoxication or Life-threatening medical condition.)

ATTACHMENT 5: ED-SPECIFIC DIVERSION PLANS AND HOSPITAL COMMUNICATION PROTOCOL FOR CASE RESPONSE

2.3.2 ED-Specific Diversion Plans

2.3.2.1 Collaboration with Hospital

Falmouth Hospital

BMC anticipates making formal arrangements with Falmouth Hospital (FH) Emergency Department (ED) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP. Outreach to FH's parent agency has been initiated.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of FH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.
- Discuss and confer with ED staff regarding best practices:
  - Processes for early notice of evaluations coupled with notification of client readiness;
  - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
  - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
  - Protocols for how CCI-ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case (See attached current policy in place with Boston EDs, *Hospital Communication Protocol for Case Response)*;
  - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with FH ED to identify current points of entry to emergency system. Develop system to assess these cases for acuity and transfer to the ESP all cases not requiring the safety and containment of ED.
- Work with FH ED to redirect its walk-ins to the Call Center and UCC for future interventions. Help FH ED educate users about options in the community for future use.
- Collaborate with FH ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.
- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using the electronic information system and refer for individualized treatment plans.

2.3.2.1.3 Minimizing Boarding

Boarding can be kept to a minimum by diligent attention to the following strategies, processes, and resources:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients;
- ED interventions emphasizing client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client;
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements;
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services (presentations at staff meeting, onsite tours of CCS programs, etc.)

- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff;
- ESP will conduct regular, thorough bed searches;
- ESP will engage in regular dialogue with SE area providers of inpatient services;
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 Rapid Response

Rapid response to FH ED will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Nantucket Cottage Hospital

BMC anticipates making formal arrangements with Nantucket Cottage Hospital (NCH) Emergency Department (ED) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP. Special attention will be paid to the limitations of this small community hospital with regard to management of psychiatric patients in need of hospitalization. The ESP will work collaboratively with hospital personnel and representatives of local community agencies and outside consultations (e.g., Riverside Trauma Center) to address the island's suicide issues among youth and adult males.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of NCH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.
- Discuss and confer with ED staff regarding best practices:
  - Processes for early notice of evaluations coupled with notification of client readiness;
  - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
  - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
  - Protocols for how ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case; and
  - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with NCH ED to develop a plan for educating Nantucket's citizens and service professionals about ESP's community services.
- Collaborate with ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.
- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using electronic information system and refer for individualized treatment plans.

2.3.2.1.3 Minimizing Boarding

Due to the complexities of limited transportation to and from Nantucket Island, boarding is a particularly difficult issue for this institution. It will take all the conventional responses outlined below to address it, plus finding creative solutions for referring and transferring clients to the CCI ESP CCS on the mainland, more intensive home intervention with clients, natural supports and island providers to preserve community tenure, and special agreements with inpatient units for prioritization of beds for the island population. Other standard practices will include:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients;
- ED interventions emphasizing client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client;
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements;
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services (presentations at staff meeting, onsite tours of CCS programs, etc.);
- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff;
- ESP will conduct regular, thorough bed searches;
- ESP will engage in regular dialogue with SE area providers of inpatient services;
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 Rapid Response

Rapid response to NCH ED will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Cape Cod Hospital

BMC anticipates making formal arrangements with Cape Cod Hospital (CCH) Emergency Department (ED) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP. Outreach to CCH and its system of care has been initiated.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of CCH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.
- Discuss and confer with ED staff regarding best practices:
  - Processes for early notice of evaluations coupled with notification of client readiness;
  - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
  - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
  - Protocols for how CCI-ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case (See attached current policy in place with Boston EDs, *Hospital Communication Protocol for Case Response)*;
  - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with CCH ED to identify sources of referral to ED and develop plan for educating referral sources about ESP's community services.
- Work with CCH ED to redirect its walk-ins to the Call Center and UCC for future interventions. Help the ED staff educate users about options in the community for future use.
- Collaborate with ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.

- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using the electronic information system and refer for individualized treatment plans.

2.3.2.1.3 Minimizing Boarding

Boarding can be kept to a minimum by diligent attention to the following strategies, processes, and resources:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients;
- ED interventions emphasizing client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client;
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements;
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services; this will include presentations at staff meeting, onsite tours of CCS programs;
- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff;
- ESP will conduct regular, thorough bed searches;
- ESP will engage in regular dialogue with SE area providers of inpatient services;
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 Rapid Response

Rapid response to Cape Cod Hospital ED will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Martha's Vineyard Hospital

BMC anticipates making formal arrangements with Martha's Vineyard Hospital (MVH) Emergency Department (ED) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP. Special attention will be paid to the limitations of this small community hospital with regard to management of psychiatric patients in need of hospitalization.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of MVH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.
- Discuss and confer with ED staff regarding best practices:
  - Processes for early notice of evaluations coupled with notification of client readiness;
  - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
  - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
  - Protocols for how CCI-ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case (See attached current policy in place with Boston EDs, *Hospital Communication Protocol for Case Response)*;

- Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with MVH ED to develop a plan for educating Martha's Vineyards's citizens and service professionals about ESP's community services.
- Collaborate with ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.
- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using the electronic information system and refer for individualized treatment plans.

2.3.2.1.3 Minimizing Boarding

Due to the complexities of limited transportation to and from Martha's Vineyard, boarding is a particularly difficult issue for this institution. It will take all the conventional responses outlined below to address it, plus finding creative solutions for referring and transferring clients to the CCI- ESP CCS on the mainland, more intensive home intervention with clients, natural supports and island providers to preserve community tenure, and special agreements with inpatient units for prioritization of beds for the island population. Other standard practices will include:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients;
- ED interventions emphasizing client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client;
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements;
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services; this will include presentations at staff meeting, onsite tours of CCS programs;
- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff;
- ESP will conduct regular, thorough bed searches;
- ESP will engage in regular dialogue with SE area providers of inpatient services;
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 Rapid Response

Rapid response to MVH ED will be a priority for our team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Cape Cod & Islands Mental Health Center (Pocasset MHC)

Though this DMH site in Pocasset does not have an ED, it will nevertheless be important to establish a close working relationship with the site's leadership and staff. Areas to address include the impact of moving the CBL out of the center and any potential concerns DMH staff may have in working with a non-DMH ESP program.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of Pocasset MHC to discuss referrals and overall communication. The move of ESP CBL to another location will require building a close collaboration to serve those clients accustomed to receiving crisis intervention at the current ESP's Pocasset site.
- Discuss and confer with center staff regarding best practices:
  - Processes for early notice of evaluations of people presenting to the center in crisis;
  - Assessing when patients under the influence of substances can be interviewed onsite;
  - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with Pocasset MHC to identify sources of referral and develop plan for educating referral sources about ESP's community services, including 800#.
- Work with Pocasset MHC to redirect its walk-ins to the Call Center and BC for future interventions. Help the center's staff educate users about options in the community for future use.
- Develop procedures for making timely, efficient referrals to the center's acute inpatient unit, helping to alleviate boarding situations in other area hospitals.
- Collaborate with Pocasset MHC's clinical, case management, and partial hospitalization staff in meeting with key community services regarding redirection of crisis situations to the ESP and away from hospital emergency departments.

2.3.2.1.3 Minimizing Boarding

Not applicable to this site.

2.3.2.1.4 Rapid Response

Rapid response to Pocasset MHC will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Hospital Communication Protocol for Case Response

Please maintain contact with the emergency department or medical floor referral source (the referring psychiatrist or social worker) throughout the process of arrival, evaluation and placement. Please adhere to these guidelines:

1. Page the referring psychiatrist or social worker **upon arrival** to inform that you are on site and starting your evaluation.
2. Contact them **at the point you have made your assessment** to discuss case and to collaborate upon the planned intervention. A mutually agreed upon plan is necessary.
3. Contact them **when the patient is ready for transfer** and a receiving facility/accepting physician has been identified. In some cases, it will be necessary to report that NO immediate placement is available and will be necessary for the patient to board until a later point in time....in some cases it will be necessary to involve the medical team, for example, if the receiving facility requests a nursing report, but the proper protocol is to channel these requests through the referring psychiatrist or social worker.

In general, please maintain good communication and contact throughout the process. It's especially important to remember that your main point of contact should be with the referring individual/department...It's ok to keep the other medical staff who are caring for the patients informed and updated, but your main point of contact should be with the referring psychiatrist or social worker.

Follow-up Assessments of Persons Who are Boarding

We may need to place people, but inpatient beds are not always available.

MBHP and other payers require a follow-up assessment, and it is good practice that we do one every 24 hours for anyone who is boarding and awaiting a placement.

At a minimum, such follow-up assessments need to include the following:

1. Current mental status examination, including a summary of client's behaviors over the past 24 hours and any interventions (e.g., medication, putting additional supports in place) over the past 24 hours
2. Description of alternative dispositions that were explored and results
3. Full bed search, if placement remains necessary, including referencing the use of Massachusetts Behavioral Health Access website
4. Communicate client's current status to appropriate contacts at the boarding site (e.g., consult liaison psychiatrist on medical floor, psychiatry resident in ED)
5. Communicate results of visit to the payer (e.g., MBHP) access line
6. Documentation of 1-5 above in the BEST/CSESP IT system, either as an addendum in the original encounter (adults) or Unit of Work (youth, within seven days of initial evaluation)

Clinician Checklist of Boarding Procedures

Please initial each item indicating that you have completed the listed task. Please use this as your fax cover sheet for paperwork you send to the office

BEST (617) 523-1207 CSESP (617) 616-5410

For Initial Evaluations:

____ **Exhaustive Bed Search Completed**. Bed Search thoroughly documented in the "follow-up" section, including reasons why facility declined referral

____ **Insurance Pre-certification completed and documented in the appropriate section**

____ **Labwork and other printed material faxed to BEST or CSESP office.** *On Weekends, faxed to the call center.*

____ **Written Evaluation/Electronic Record Updated** *including all pertinent components of the "client summary section" completed.*

____ **Communication with Referral Source** *Emergency Room Contacts (psych resident, attending, etc. informed of status of the placement*

For 24-hour re-evaluations

____ **Specific to MCI Cases** *all MCI (age 20 and under), all work which takes place within 7 days of the initial encounter is documented as a unit of work...not as a new encounter*
For Adult cases: *do not enter a new encounter. All follow-up notes are written in the follow-up section.*

____ **New MSE, thorough assessment, and summary of and pertinent changes since the most recent (usually the day before) evaluation is clearly documented in your written evaluation, in the "follow-up" section**

____ **Labwork and other printed material faxed to BEST or CSESP office.** *On Weekends, faxed to the call center*

____ **Communication with Referral Source** *Emergency Room Contacts (psych resident, attending, etc. informed of status of the placement*

____ **Written Evaluation/Electronic Record Updated** *including all pertinent components of the "client summary section" completed.*

____ **Insurance Company** is contacted is updated and you have documented who you spoke with. Informing them if the client is still boarded, or if they will be discharged, sent to CCS, etc.

ATTACHMENT 6: PROFESSIONAL DEVELOPMENT ACTIVITIES AND TRAININGS OVER LAST TWO YEARS

BMC trainings:

The below trainings were held at BMC over the past two years.

- Peer-Driven Recovery and Resources, Metro Boston Recovery Learning Community, various staff
- The Power of Peer Support, RLC leaders for Grand Rounds
- The Principles of Recovery and the Role of Peer to Peer Services
- Motivational Interviewing

Bay Cove trainings:

Below is a sample list of available trainings.

- Principles of Rehabilitation and Recovery
- Person Centered Planning
- Motivational Interviewing
- Development of Rehabilitation Plans
- Health and Wellness: Building a Wellness Vision
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Thomas Brown Trauma Informed Training—developed as part of a graduate program by a BC Peer Specialist, it relies on the presenter's personal experiences with trauma, as well as those of the trainees and the neurological effects of repeated trauma on the survivor

Vinfen trainings:

- Recovery Milestones (Milestones of Recovery) – 2 hours
- Co-Occurring Disorders – 3.5 hours
- Partnerships for Recovery – 4 hours
- The Practice of Psychiatric Rehabilitation – 4 hours
- Ethics and Human Rights – 4 hours
- Developing Great Wellness and Recovery Action Plans (WRAPs) – 3 hours
- Wellness Recovery Action Plan (WRAP) Facilitator Trainings – 5 day/8 hour training
- Hearing Voices That Are Disturbing – 4 hours

ATTACHMENT 7: COMMITMENT TO CULTURAL DIVERSITY

MEMORANDUM

TO: All BMC Employees

FROM: Kate Walsh, President and CEO

DATE: March 2014

RE: Diversity Statement

Boston Medical Center is proud to be an integral part of the diverse community of Boston. It is this community, comprised of people from a wide variety of cultures and backgrounds, that BMC draws upon as a resource for its employees and its patients.

As part of its stated mission and values, BMC remains committed to creating and sustaining a work place and a hospital where we respect and value employees, patients, and patients' families not in spite of, but because of, the differences in their backgrounds and cultures. We believe there is strength in diversity, not only of race, gender, age, religion, and disability, but also of education, politics, family status, national origin, sexual orientation, gender identity and/or expression and all of the other factors that make people individuals.

Honoring the diversity of our community will promote and ensure the mutual respect, collaboration, and productivity that is necessary to provide the highest quality health care.

ATTACHMENT 8

Bay Cove Urgent Care Center/CBL
RE.P.O.R.T.
(Reviewing Every Patient and Offering a Reliable Transition)

Please note the following requirements for responsible patient handoff for all people evaluated through the CBL (mobile and at the UCC).

Situation/ disposition	Communication Procedure	Documentation requirements
Day to evening clinician	• Communicate verbal information to pass the incomplete evaluation and disposition work from one C to another C where possible. • If another C not available, communicate to supervisor in charge • If another C or supervisor in charge are unavailable, communicate to Call Center staff • Reminder — with children and adolescents, be sure to review with BMC MCI (weekdays) or Attending on call (evenings and nights) • Inform patient and family if you are passing along their information and what they can expect	• Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.
Evening to night clinician	• Communicate verbal information to pass the incomplete evaluation and disposition work from one C to another C where possible. This should be accomplished by telephone. • If the night clinician has already been dispatched for another evaluation, communicate all needed information to the Call Center staff. They will pass this information along to the night on-call C when they are available. • Reminder — with children and adolescents, be sure to review with the Attending on call (evenings and nights). • Inform patient and family if you are passing along their information and what they can expect.	• Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.
Night to morning clinician	• Communicate verbal information to pass the incomplete evaluation and disposition work to the Call Center staff. This should be accomplished by telephone. The Call Center staff will pass along to day staff. • Reminder — with children and adolescents, be sure to review with the Attending on call (evenings and nights). • Inform patient and family if you are passing along their information and what they can expect	• Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.

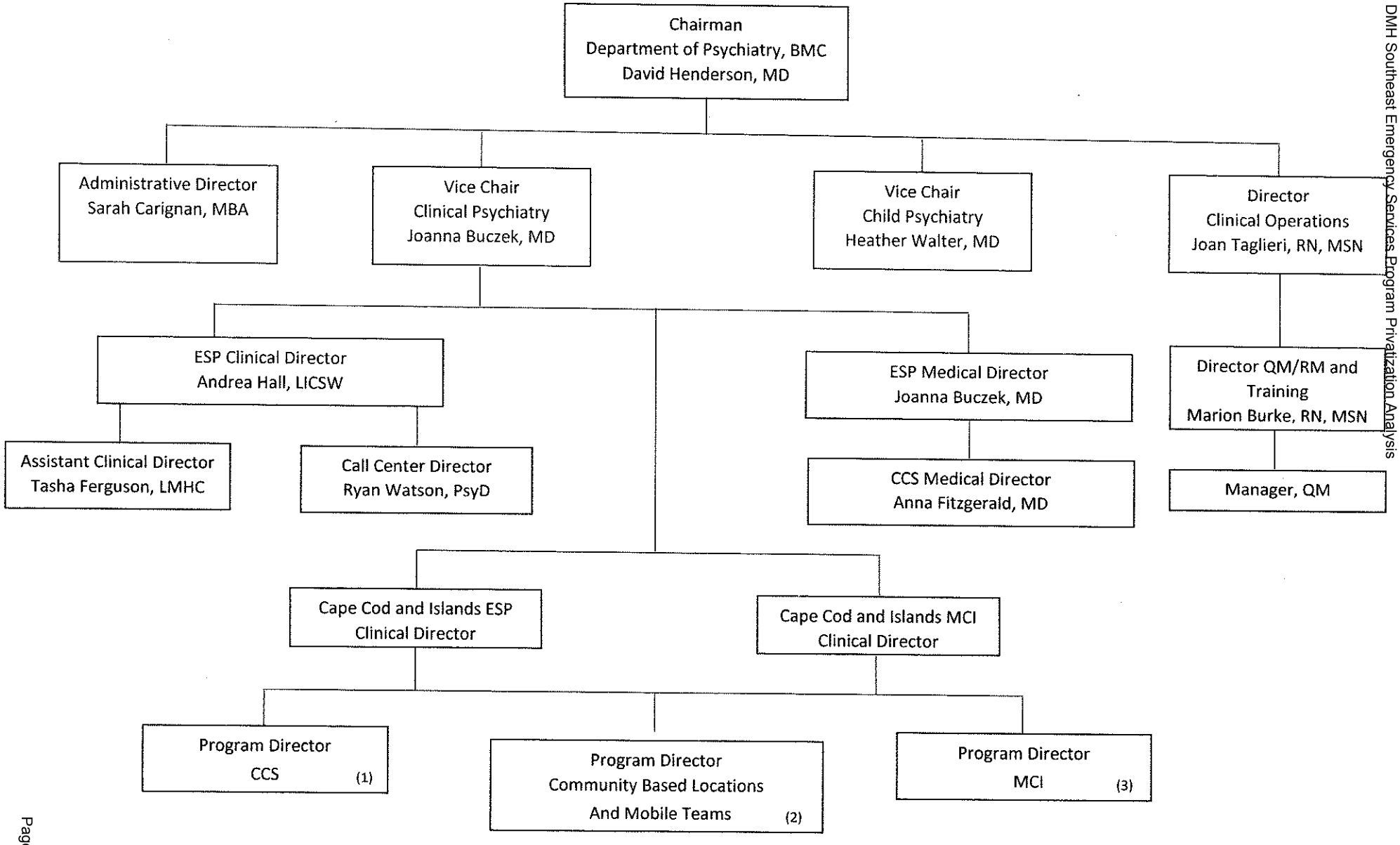
Situation/ disposition	Communication Procedure	Documentation requirements
Clinician to ED staff	• Inform them of status of evaluation and any patient safety concerns. • Inform them about disposition or expected outcome. • Request any medical support needed (labs, etc.).	• Complete the evaluation. • Make a copy of the eval and file in the medical chart.
Clinician to CCS	• Communicate reason for admission and facilitate nurse to nurse report (if Pt was evaluated in the ED). • Secure medical clearance as needed. • Introduce patient to the CCS staff. • Notify DMH police regarding pending admission to CCS.	• Complete evaluation so that CCS staff can access through BEST IS at admission.
Clinician to patient and family	• In all circumstances where a handoff is needed, inform the patient and their family regarding what they can expect. • If the eval is done and the person returns home, inform them of follow up appointments or how to access follow up support if needed	• Include in the eval and chart. Complete discharge plan and hand to patient or family.
Clinician to community care providers	If the eval is complete and the disposition is for the person to go home or to outpatient or partial services, notify community providers by telephone.	Document collateral contacts in the pt's eval.
Clinician to Call Center stall	At end of each shift notify Call Center staff of the status of all evaluations.	Document notification in evaluation.

COLOR CODING	Awaiting call back	Any text in just BOLD is a f/u contact	On site pending cases for clients who have not arrived yet	A case that [illegible] for a minor (12)		Scheduled community visits later (today)		MCI hand-offs from other teams	Not seen yet but assigned
Date	Time	CC Clinician	Client	Location	Clinician Assigned	Time Clinician Informed	x-Initials When Case Completed	Clinician Return/End Time	Notes
6/15/2015	6:15 PM	Laurent	CT	CHB ED	Crystal				
6/15/2015	6:02 PM	Laurent	CT	bayview inn	Elie				
6/15/2015	5:05 PM	Laurent	CT	Yawkey Bldg 4th Flr	Crystal				
6/15/2015	4:24 PM	MCI hand off	CT	Dorchester	Patrick & Ashley				
6/15/2015	4:21 PM	walk in	CT	on site	Elie & Marty				
6/15/2015	3:46 PM	laurent	CT	HV Matt	Heidi				
6/15/2015	3:41 PM	Joanne	CT	Carney ED	Ben				
6/15/2015	3:23 PM	Daphna	CT	on site	alex & marty				
6/15/2015	2.14pm	paul	CT	campus)	Alex				
6/15/2015	1:43 PM	Joanne	CT	on site 3-3:30 PM	Jaime/Ashley				
6/15/2015	1:11 PM	Don	CT	Dorchester-Grp Home	Heidi				
6/15/2015	12:44 PM	Paul	CT	HV Dorchester	Erin				
6/15/2015		MSE	CT	CHB 9E	no longer considering d/c for today see UOW				
6/15/2015		MSE	CT	CHB ED	Cancelled				
6/15/2015		MSE	CT	CHB ED	Michael				
6/15/2015		MSE	CT	CHB ED	Michael				
6/15/2015		MSE	CT	CHB 9NE	Michael				
6/15/2015		MSE	CT	CHB 7W	Michael				
6/15/2015		MSE	CT	CHB 6NE	Michael				
6/15/2015	11:24 AM	Paul	CT	Carney 3NE	Ben				
6/15/2015	11:24 AM	Paul	CT	ICU Carney	Francesca 2				
6/15/2015	11:09 AM	Joanne	CT	ICU Carney	Francesca 3				
6/15/2015	11:09 AM	Joanne	CT	Carney [moving from ICU to 3NE]	Ben				
6/15/2015	10:58 AM	Paul	CT	Coomunity Accademy Dorchester	Mike				
6/15/2015	10:30 AM	Walk-in	CT	on-site	Olga/Marty				
6/15/2015	10:08 AM	Paul	CT	The Spot--Roxbury	Heidi				
6/15/2015	10:07 AM	walk in	CT	On-site	Jaime/Olga				
6/15/2015	9:15 AM	Walk in	CT	On-site	Erin				
6/15/2015	9:15 AM	Joanne	CT	Carney	Francesca 1				
6/15/2015	9:00 AM	Don	CT	onsite	Erin				

ATTACHMENT 10: ESP DIRECTOR QUALIFICATIONS

- Level of knowledge equivalent to Master's degree in Psychology, Social Work, Nursing or in Counseling. Requires current Massachusetts Licensure.
- Minimum of five to seven years of supervisory experience in a psychiatric setting. Experience in the provision of emergency services strongly preferred.
- Demonstrated clinical and supervisory skills.
- Demonstrated ability to work with key stakeholders, including funders, subcontractors, state agencies
- Ability to provide leadership and coordinate the work of a team of assigned team members.
- Excellent oral and written communication skills; ability to be detailed oriented in all notes and documentation.
- Demonstrated ability and experience in areas such as grant management, training, team building, program development/management, problem solving, and community building.
- Ability to analyze needs and apply resources effectively to meet those needs.
- Ability to achieve targeted results through motivating, mobilizing, and delegating to others.
- Ability to work in a multicultural environment.
- Experience with Windows, Word, Excel, Outlook, Internet and web page usage/updating, social networking and other technologies that can be used to further carry the program's mission.

Attachment 13: Boston Medical Center Cape Cod and Islands Emergency Services Program Organizational Chart



(1) Services Provided by Vinfen and BMC Psychiatry
(2)(3) Services provided by Bay Core Human Services

ATTACHMENT 14: RESPONSE TO REQUESTS FOR COMMUNITY-BASED EVALUATION IN SITUATIONS FELT TO BE DANGEROUS

BOSTON MEDICAL CENTER

DIVISION OF PSYCHIATRY
BEHAVIORAL HEALTH SERVICE
BMC BEST/ Cambridge-Somerville ESPs

Policy: Response to Requests for Community-based Evaluation in Situations Felt to Be Dangerous
Policy number: 023
Date issued: 11/05
Date revised:
Date reviewed: 5/10

Mission Statement and Non-Discrimination Policy:
We will provide consistently excellent and accessible health service to all in need of care, regardless of status or ability to pay. Patients' diversity is respected and we are sensitive to ethnic, cultural, gender, sexual orientation, and religious differences.

Purpose of Policy:
To define the process to be followed when BEST/C-S ESP receives a request to perform a community-based evaluation and the BEST clinician raises a question of potential danger in meeting such a request.

Scope of Policy:
All team members within the BEST/C-S ESP program

Substance of Policy:
If the BEST/C-S ESP Call Center receives a request to perform an evaluation in the community (e.g. a home) that is felt by the Call Center clinician and/or the Mobile Team clinician to pose a potential threat to the clinician's safety (or to the safety of the person him/herself, a family member or other person in the situation), the clinician in question will call his/her supervisor who will contact the Clinical Director of the BEST/C-S ESP Team to discuss the particulars of the situation. If necessary, the Clinical Director will confer with the Medical Director. Following discussion, a determination of how to respond shall be made. . If the Clinical and Medical Directors feel that it is unsafe for the clinician to respond to the community site, several options are possible:

- Provide a two-person response if this is sufficient to alleviate safety concerns
- the requester of the evaluation will be directed to have the patient brought to BMC Emergency Department for BEST and Cambridge Hospital PES for CSESP

- the Call Center at BMC can assist with a Section 12 for instances in which the client's presentation is the source of the safety concern and Section 12 criteria is met
- the BEST/C-S ESP Team will request that a member of the Police force meet them at the site as stand-by

A log of requests not met due to the danger posed shall be maintained by the BEST Call Center. This shall also be documented in the patient's electronic record, generated when the call is received by the Call Center.

Documentation Requirements:
As described above

Implementation:
The Clinical Director of the BEST/C-S ESP Team is responsible for the implementation of this policy.

Policy Review:
The Director of Quality/Risk Management for the BEST/C-S ESP Program shall ensure biannual review of this policy.

ATTACHMENT 15: CHILD-FOCUSED TEAM DESCRIPTION

BEST and CS-ESP mobile teams (as well as MCI teams across the state) have the ability to provide up to 7 days of service to youth under age 21 and their families following an initial encounter. This increase from the former 72 hour standard was initiated by the MassHealth Office of Behavioral Health with the intention of providing greater opportunities for stabilization in the community to youth and families experiencing crisis.

The mobile team offices (BayCove, NorthSuffolk, and Cambridge/Somerville) house a Child Focused Team, which monitor youth follow-ups in the community, and ensure a high standard of care for both planning and carrying out interventions. Each Child Focused team consists of a youth team leader, full-time clinician(s), and family partner(s) who work together to meet the needs identified by the youth and family.

- The system for triaging and responding to requests for new evaluations remains unchanged—the Child Focused Team will be primarily responsible for providing interventions to youth and families after the point of the initial evaluation, including MCI Hand-offs from the EDs;
- ED staff can continue to request community-based follow-up for youth clients through the BEST Call Center;
- When documenting CBHI-eligible cases (MassHealth and uninsured clients) please open a new encounter **only every 7 days**, using units of work to document activity on days 2-6; and
- For non-CBHI eligible cases (Harvard Pilgrim and Commonwealth care clients) please open a new encounter daily—as with adult clients—and **do not use units of work**.

This expanded length of service to youth and families gives an exciting opportunity for BEST and CS-ESP to continue to provide more comprehensive community-based care, thereby allowing families to be served in the least restrictive and most individualized way possible.

ATTACHMENT 16: YOUTH CONSULTATION PROTOCOL

BEST/CSESP On-Call Consultation Protocol for Youth (age 0-20) – for Mobile Teams

This protocol assures that every youth case will be reviewed with a licensed supervisor, ***either*** at the BMC attending level or mobile team supervisor.

1. Review with BMC Attending

The BMC attending (weekdays – clinical director or MCI manager; off-hours – psychiatrist) should be contacted in real time for youth encounters when they involve any of the following:

- The initial complaint alleged acute safety issues – e.g., suicidal ideation, homicidal ideation, or question of psychosis
- The clinician wants to refer the youth to a 24-hour level of care
    - This would include youth who will board in the community awaiting CBAT
- Review for issuing Section 12A
- For youth 18 and older, review for CCS placement **(with CCS APRN weekdays)**
- The evaluating clinician has not been able to reach consensus about disposition with youth, family and collaterals, and the situation cannot be resolved at the team supervisor level (e.g., Doc-to-Doc is required; MCI Manager needed to provide guidance)
- All individuals being discharged to community from Somerville ED and Carney ED.
- Medical-related questions
- 51A filings against a program or employee of a program
- On an as-needed basis; clinicians should always feel free to seek consultation from the BMC attending

2. Review with Mobile Team Supervisor

When **ALL** the following conditions are met, the clinician will review with licensed mobile team supervisor and is not required to contact the BMC attending:

- No acute risk factors have been reported
- A 24-hour level of care is not indicated
- All parties to the evaluation are in agreement about the proposed disposition and follow-up
- 51A filings except as described above

ATTACHMENT 17: YOUTH BOARDING PROTOCOL

DIVISION OF PSYCHIATRY
BEHAVIORAL HEALTH SERVICE
BMC BEST/Cambridge-Somerville ESP Program

Policy: Boarding Youth in the Community

Policy number:
Date issued: 12/10
Date revised: 8/15

Mission Statement and Non-Discrimination Policy:
We will provide consistently excellent and accessible health service to all in need of care, regardless of status or ability to pay. Patients' diversity is respected and we are sensitive to ethnic, cultural, gender, sexual orientation, and religious differences.

Purpose of Policy:
To define the standards and procedures for managing and maintaining safety of a youth boarding in the community as they await a 24 hour level of care placement

Scope of Policy:
All components of BEST and Cambridge-Somerville ESPs

Substance of Policy:
Whenever a decision is made by the ESP mobile team that a youth waiting for a bed in a 24-hour level of care may be safely managed in the community until placement in that bed, the procedure outlined below shall be followed.

Procedure:
The following steps shall be taken by MCI/mobile team clinicians following the decision to maintain a youth in the community as s/he awaits placement in a 24-hour level of care:

- Review the clinical assessment of the youth with the designated attending psychiatrist on-call and obtain that psychiatrist's agreement to community boarding
- Document the details of the initial bed search that resulted in the need to board the youth. If a bed had been available, but parent/guardian declined that placement, include that fact and the reason for the declination in the documentation
- Document the guardian/family and receiving facility's agreement to the community boarding plan. Complete a Youth Risk Management Safety Plan,

detailing a plan for safely managing the youth for the duration of community boarding

- In the web-based clinical encounter, check client boarding box and indicate "community" in answer to the query, "If boarded, where?"
- In the "follow-up" section of the encounter, specify the following:
  - Youth must be reassessed daily for purpose of assessing safety and for determination that 24-hour level of care is still appropriate. These reassessments shall be documented as a Unit of Work until the youth is placed or a period of 7 days has passed. A new encounter shall be completed after 7 days of community boarding.
  - All other interventions by clinicians or family partners that occur within the 7 days shall also be documented as Units of Work.
  - A bed search shall be conducted every shift during the boarding period And shall be documented as a Unit of Work
- During daily MCI rounds, the responsible team shall discuss all youth boarding in the community
- Each time the decision is made to board a youth in the community, the responsible clinician shall notify the Medical Director for ESPs, Joanna Buczek, MD, (Joanna.Buczek@bmc.org) by email. That clinician shall also copy the email to the respective team's Youth Director/Team Leader and to the MCI Program Manager (Tasha.Ferguson@bmc.org). In the email, include
  - Name of youth
  - Exact name of where boarded (e.g. home, with address; name/address of group home or other facility)
  - Indication that a Risk Management Safety Plan was completed and was left with the family or facility staff member

Documentation Requirements:
As described above

Implementation:
The Clinical Director for ESPs and the MCI Program Manager are responsible for the implementation of this policy.

Policy Review:
The Director of Quality/Risk Management for the BEST Program shall ensure biannual review of this policy.

ATTACHMENT 18: MCI HAND-OFF

CHECKLIST FOR HAND-OFFS BETWEEN BEST/CSESP Designated EDs, CALL CENTER, and MOBILE TEAMS

Responsibilities of ED clinicians

- Prepare family for follow-up
- Clearly state purpose of MCI intervention in the encounter recommendations (e.g., ongoing safety assessment, involving Family Partner to support parent)
- Triage hand-off with Call Center (1-800-981-4357)
- Provide full encounter
    - Goal: simultaneous entry in BEST/CSESP electronic system
    - If not in electronic system, fax paperwork to Call Center

Responsibilities of Call Center

- Write triage in BEST/CSESP IT system
- **It is particularly important to get all contact information to ensure successful follow up.**
- Use "Handoff to MCI" as primary disposition
- Use appropriate mobile team as "disposition where"
- Request of ED clinician calling that encounter be entered simultaneously in electronic system
    - Obtain faxed copy of assessment if not available yet in BEST/CSESP system
- Convey hand-off to appropriate mobile team child focused team via e-mail—see ***Attachment A*** for list of e-mails by team
    - Hand-offs for next day will be held on Call Center follow-up board
- Provide faxed evaluation to mobile team, only if not in electronic system

Responsibilities of Mobile Team

- Arrange follow-up as requested in encounter recommendations
- Monitor and take ownership of MCI cases until resolved
- If case will require weekend response/contact, be sure to "loop" back to Call Center for coordination of weekend follow-up
- Review status of all hand-offs with MCI Manager during rounds

Position Description: Child Focused Clinician

Responsibilities:
The BEST Urgent Care/Mobile Team provides direct services to children and adults in crisis through assessment of each person's need for services and development of a treatment plan that best ensures for their safety and optimizes effective resolution of the crisis. Facilitates the person's engagement or re-engagement in behavioral health services through referral to community based services that are consonant with the person's needs and preferences. As needed, the Clinician facilitates the person's admission to acute treatment services.

In addition to responsibilities of the general service noted above, the Child Clinician focuses on nuanced interventions with youth and families. Youth under the age of 21 are eligible for Mobile Crisis Intervention (MCI), which is a short-term service for those experiencing a behavioral health crisis that focuses on stabilization and reduction of risk. The role of the Child Clinician is to carry out the ongoing follow up associated with the intervention for up to seven days. Responsibilities include:

- Engagement in an ongoing crisis planning process
- Advance communication with treatment providers, schools, natural supports, and other youth-serving systems
- Referrals/linkages to behavioral health services and supports
- Telephonic and/or in person therapeutic response to the youth and their family

Qualifications:
Licensed Master's level clinician. License eligible acceptable. Minimally 3 years experience working in a mental health setting. Excellent writing and oral communication skills. Current Massachusetts Driver's License and use of reliable personal vehicle for work related travel.

BAY COVE HUMAN SERVICES, INC.

Position Title: BEST Mobile Crisis Child Team Leader

Department: BEST

Reports To: Service Director, BEST

Mission Statement:
Our Mission is to provide high-quality services to children and adults who face the life-long challenges of mental illness, drug and alcohol dependency, and developmental disabilities.

Job Summary:
The BEST Mobile Crisis Child Team Leader provides direct services to children and adults in crisis. This Clinician assesses each person's needs for services and develops a treatment plan that best ensures for their safety and optimizes their effective resolution of the crisis. S/he facilitates the person's engagement or re-engagement in behavioral health services through referral to community based services that are consonant with the person's needs and preferences. As needed, the Child Team Leader facilitates the person's admission to acute treatment services.

The Clinician works as part of an Urgent Care Center that provides on site assessment and support, as well as mobile capacity to conduct assessments at the person's home, school, or agency in Greater Boston. S/he works as a partner in an integrated urgent care/emergency support services network (and as a result may provide services in the CSU or sister Urgent Care Center/Mobile Team). Given the nature of crisis services, provision of holiday and weekend coverage are expectations for staff working in this position. This position is non-exempt.

Essential Functions of Position:

- Ensure completion of tasks, follow up, and case assignments pertinent to MCI (Mobile Crisis Intervention)
- Conduct assessments and provide oversight of ongoing case management of active MCI cases
- Provide support to Service Director and Assistant Program Director with supervision of staff, supervision and training of students in busy Urgent Care Center/Mobile Crisis Service (affiliation with B.E.S.T.)
- Sharing of administrative on call in rotation with Service Director/Asst. Director (24/7/365 coverage).

- Provides services in a manner that is consonant with program, BayCove, and collaborative agencies' standards, policies, and procedures
- Completes assessments of children and adults who are in crisis in a comprehensive manner attending to their safety and needs
- Develops treatment plans with and for the person in crisis that utilize community based health, behavioral health, and social services that will ameliorate the presenting crisis
- Works with the person in crisis and their support network to fortify their strengths and coping skills
- Works collaboratively with members of the BEST team and collateral helpers in the service of strengthening and integrating support and treatment supports and to accomplish the overall program's mission
- Assists the person in crises with engagement or reengagement in needed services
- Documents all assessments and interventions in accordance with program and BayCove standards
- Secures as needed financial and insurance related information to facilitate billing and payment for services rendered
- Recognizes the importance of individual and cultural differences that influence behavior and applies such understanding to each person's situation
- Utilizes individual supervision and team meetings in the service of optimizing the program's overall mission
- Maintains requisite continuing professional education as required by licensure, professional standards and BayCove policies
- Works effectively with police, DSCFMHC Security, and other law enforcement personnel to ensure the client's safety
- Facilitates admission to acute inpatient care on an as needed basis
- Relates to clients, family members, and colleagues in a professional, hopeful, and respectful manner
- Provides brief treatment and support until requisite community services can be accessed in order to minimize reliance on acute inpatient services
- Performs all other duties and projects as assigned by the Program Director.

Job Responsibilities/Job Related Competencies and Skills

- Demonstrated assessment and treatment skills in the provision of emergency services for children and, as needed, adults.
- Demonstrated ability to de-escalate crises in a manner that ensures safety for all involved and provides for the best care and welfare of the person in crisis
- Able to assess needs and implement interventions in accordance with best practice standards for emergency care, crisis resolution, and recovery
- Demonstrated professional writing, communication, and organizational skills

- Ability to assess crisis emergency situations and address with appropriate clinical treatment for clients.
- Demonstrated knowledge of risk assessment specific to acute psychiatric conditions for children and adults.
- Demonstrated assessment and treatment skills in the provision of emergency services for children and adults
- Demonstrated knowledge of varying social and behavioral health services and the nature of the treatment, rehabilitation, and supports that they offer. Can determine the persons needs for services, refer to the appropriate resource(s), and facilitate the person's engagement in these services
- Demonstrated knowledge of the evaluation process, including presenting problem, social, family, psychiatric, legal, and medical history. Capacity to effectively assess mental status, formulate a plan, and develop an implement an appropriate disposition for all clients
- Demonstrated ability to identify needs and strengths, assist in planning, implementing and evaluating care of individuals and their families in conjunction with an array of community resources.
- Demonstrated professional documentation skills

Physical Requirements

- Must be able to drive to different locations.
- Must have the ability to assess children and adults in their homes and apartments with stairs.
- Must be able to observe the person in crisis, noting symptoms and nonverbal behaviors

Qualifications:

- Licensed Master's level clinician.
- Minimally 3 years experience working in a mental health setting.
- Excellent writing and oral communication skills.
- Current Massachusetts Driver's License and use of reliable personal vehicle for work related travel

Personal Characteristics:

- Demonstrated ability to work in a pressured situation and maintain clarity, focus, judgment, and compassion
- Flexibility
- Ability to work with people in crisis in a hopeful and compassionate manner
- Ability to communicate concerns effectively to other team members and ask for help as needed
- Ability to work independently

This job description is intended only to provide general guidance. It is understood that the position may evolve over time, and that additional or different duties may be added at management's discretion. It is the policy of Bay Cove Human Services, Inc., to review and update job descriptions annually; however, updates or revisions may occur within a given year as indicated.

Division:	Boston Emergency Services Team
Category:	Professional - Other
Program:	BEST UCC
Position:	Family Partner
Requires resume:	Yes
Requires Professional License:	No

Responsibilities: The Family Partner works with other members of the ESP Urgent Care and Mobile Crisis teams and provides peer support to parents served by the program. Peer support is defined as using personal and professional life experiences to establish credibility and infuse hope for a better future, to demonstrate unconditional acceptance, and to assist with problem solving. Additionally, the Family Partner serves as a "values speaker", specifically, but not limited to providing a parent's perspective in the routine operations and development of the program. The Family Partner uses personal and professional life experience to provide consultation and training for staff and others to increase awareness and improve the effectiveness of parent-professional partnerships to meet the needs of families, and to participate in program and community meetings to maximize parent voice, choice, and involvement throughout the service delivery process.
The family partner will be involved in the ongoing follow up for families served by the mobile team. This includes telephonic and face-to-face interventions, identifying resources for families, initiating referrals in service of establishing wrap around supports, and acting as a liaison with current providers, schools, and state agencies.
The parent partner provides parents and caregivers with information about the ESP and the wraparound process and resources to assist them to successfully engage; Learns the family's story, culture, strengths, and concerns; Provides non-judgmental, unconditional support to parents and caregivers; Participates in implementing a variety of support services for parents/care givers; Produces and maintains accurate and timely documentation.

Qualifications: ***-Lived experience as the primary caregiver for a youth who has received mental health or behavioral health services.*** This can be as a biological parent, foster parent, or another familial relationship in which the applicant is in a primary parental role.
-Ability to work collaboratively as a member of multi-disciplinary and cross-functional teams.
-Demonstrated ability to work in a pressured situation and maintain clarity, focus, judgment, and compassion
-Ability to work with people in crisis in a hopeful and compassionate manner and

model this for others
-Ability to work independently
-Basic computer skills
-Language capacity strongly preferred

Drivers License Required: Yes

Hours:

TBD

Schedule:

40 hrs, some weekend/evening/holiday coverage

Salary: TBD

New Position: No

Employee Signature: _____

BOSTON MEDICAL CENTER

JOB TITLE:	Program Director, Youth Mobile Crisis Intervention	**DEPARTMENT:**	Psychiatry
CODE:	50001021	**FLSA STATUS:**	Exempt
REPORTS TO:	Clinical Director, BEST and CSESP	**GRADE:**	M16A
SUPERVISES:	Clinical: Masters Level Trainees; Unlicensed Masters Level Clinicians Administrative: staff and trainees	**DATE:**	05/26/2009
BLDG/LOCATION:		**UNION STATUS:**	Non-Union

APPROVALS
DIRECTOR: _____ VP: _____ HR: _____

POSITION SUMMARY:

Manages clinical operations for youth for Emergency Service Programs (ESPs); provides clinical care to children and adolescents; provides teaching and supervision to staff clinicians and trainees; acts as liaison with internal and external entities; engages in mental health advocacy activities.

ESSENTIAL RESPONSIBILITIES / DUTIES:

Works collaboratively with Clinical Director of ESPs and the Medical Director of ESPs to create and manage a seamless system of child mental health services for Boston Medical Center's emergency services programs.

1. Plays a key role in developing the vision, mission, and strategic objectives of BMC ESP services for youth.
2. Works collaboratively with ESP leadership to create seamless coordination between emergency, crisis stabilization, urgent care, outpatient, and consultation services in child psychiatry.
3. Manages the day-to-day clinical activities of the ESPs in relation to youth, including assessment, treatment, transfer, and discharge of patients.
4. Together with the Clinical Director of ESPs and Director of QM/RM, develops and implements quality initiatives, including staff training, medical record audits, monitoring/reporting of significant clinical events, monitoring/recording patient/family satisfaction, and monitoring/recording satisfaction of referral sources.
5. Manages complaints from all key constituent groups; triages complaints to Medical Director and Clinical Director of ESPs as indicated.
6. Provides clinical care in outpatient, urgent care, crisis stabilization, emergency, and consultation settings.
8. Together with the Clinical Director of ESPs, functions as a key clinical liaison with BMC child psychiatry and pediatric services.
9. Together with the Clinical Director of ESPs, functions as a key clinical liaison with MBHP, DMA, DMH, DSS, DYS, and other state and city agencies.
10. Together with the Clinical Director of ESPs, meets with key stakeholders to communicate the vision, mission, and strategic goals of the program.
11. Together with the ESP programs, maintains an up-to-date listing of and liaison with mental health service providers, including hospitals, family stabilization teams, outpatient facilities, residential facilities and shelters.
12. Maintains an up-to-date listing of and liaison with social service resources for families.
13. Together with the Clinical Director of ESPs, Medical Director, and Director of QM/RM, develops policies and procedures for outpatient mental health services; facilitates adherence to policies and procedures among clinical staff.
14. Facilitates compliance with all regulatory imperatives, including Joint Commission, hospital, and professional.
15. Maintains personnel files for all clinical staff, including current CV, current job description, core competency ratings, mandatory education requirements, continuing education requirements, and yearly performance evaluation/goals and objectives.
16. Monitors clinician productivity on a monthly basis; creates action plans to address productivity deficits.
17. Participates in key administrative, quality management, and clinical leadership committees.
18. Together with the Clinical Director of ESPs and ESP leadership, creates orientation and training programs for ESP staff.
19. Together with the Clinical Director of ESPs and ESP leadership, hires, orients and evaluates staff performance.
20. Together with the Medical Director, provides orientation to trainees around program policies and procedures.
21. Provides clinical supervision to master's level trainees and unlicensed masters level clinicians as assigned.
22. Manages office space.
23. Maintains time off records for staff clinicians.
24. Maintains clinician work schedules.
25. Conforms to hospital standards of performance and conduct, including those pertaining to patient rights, to ensure that exceptional customer service and patient care may be provided.

26. Utilizes hospital's values as the basis for decision-making and to facilitate the hospital's mission.
27. Follow established hospital infection control and safety procedures.

OTHER DUTIES:
Perform other duties as needed.

(The above statements in this job description are intended to depict the general nature and level of work assigned to the employee(s) in this job. The above is not intended to represent an exhaustive list of accountable duties and responsibilities required).

JOB REQUIREMENTS

EDUCATION:

Masters degree in Social Work.

CERTIFICATES, LICENSES, REGISTRATIONS REQUIRED:

Current Social Work licensure in the Commonwealth of Massachusetts

EXPERIENCE:

Minimum of five to seven years of clinical and supervisory experience in a psychiatric setting

KNOWLEDGE AND SKILLS:

1. Demonstrated clinical, supervisory, collaborative, team building, and interpersonal skills.
2. Demonstrated skill in the provision of services in a multicultural environment.

AGES OF POPULATION SERVED:

Employees in this position must be competent to provide care to the following age groups: Check all that apply:

☐ Neonatal: Birth to 1 month	☐ Infant: To 1 yrs	☑ Toddler: 1 to 3 yrs	☑ Pre-school: 3 – 6 yrs
☑ School age: 6 – 12 yrs	☑ Adolescent: 12 – 18 yrs	☐ Young Adult: 18 – 30 yrs	☐ Middle age: 30 – 60 yrs
☐ Elderly: 60 – over	☐ Not Applicable		

SPECIAL WORKING CONDITIONS (RESPONSIBLE FOR ON-CALL, 24 HR. COVERAGE, ETC.):

External and internal applicants, as well as position incumbents who become disabled as defined under the Americans With Disabilities Act, must be able to perform the essential job functions (as listed) either unaided or with the assistance of a reasonable accommodation to be determined by management on a case-by-case basis.

PHYSICAL AND ENVIRONMENTAL DEMANDS

This form is used to assist departments in identifying the physical and environmental demands of the position .

Physical Demands Without Accommodations	Hours at one time 0	<1/2	½-1	1-2	2-4	Total Hours per day <1	1-2	2-4	4-6	6-8
Sitting					√				√	
Walking		√				√				
Standing		√				√				
Bending Neck		√				√				
Twisting Neck		√					√			
Bending Waist (Forward or sideways)		√				√				
Twisting Waist		√				√				
Squatting	√					√				
Climbing	√					√				
Kneeling	√					√				
Crawling	√					√				
Repetitive Movement: Hand		√							√	
☐ Simple grasping: 1 hand__ both__		√						√		
☐ Power grasping: 1 hand__ both__	√					√				
☐ Fine Manipulation: 1 hand__ both__	√					√				
☐ Pushing/Pulling: 1 hand__ both__	√					√				
Reaching above shoulder height	√					√				
Reaching below shoulder height	√					√				
Moving items weighing up to 10 lbs.		√				√				
Moving items weighing 11 – 25 lbs.		√				√				
Moving items weighing 26 – 50 lbs.	√					√				
Moving items weighing 51 – 75 lbs.	√					√				
Moving items weighing 76 – 100 lbs.	√					√				
Moving items weighing over 100 lbs.	√					√				

Environmental Demands (Check all that apply)

- ☐ Extreme Cold (below 32 degrees) Source_____
- ☐ Extreme Heat (above 100 degrees) Source_____
- ☐ Noise (Need to shout to be heard) Source_____
- ☐ Vibration Source_____
- ☐ Exposure to dust, gas, fumes, steam, chemicals Source_____
- ☐ Work outdoors (no effective protection from weather)
- ☐ Work at heights (such as scaffolding or ladders)
- ☐ Protective equipment required (Respirator, earplugs, mask, gloves, eyewear, etc) _____
- ☐ Potential exposure to infectious diseases.
- ☑ None (Not substantially exposed to adverse environmental conditions).

Technology Response Attachments

Fiscal Response Attachments

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 1 **ORGANIZATION:** CAPE COD - ONE AREA **FY END:** 2016

This schedule provides supplemental information for selected programs on an aggregated basis for use by the Commonwealth's Division of Health Care Finance and Policy in the establishment of so called "Class Rate" prices for certain Medi

1. UFR Program Numbers providing Mental Health Class Rate Services:

2. Program Staff and Expense Breakout by Service Component

Note: Schedule B positions not listed below are non-reimbursable for MH Class Rate services.	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE		ESP Admin	
	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS
1S Program Director	0.75	60,571	0.080	7,200	0.250	18,821	0.120	10,575	0.050	4,725	0.25	19,250
2S Program Function Manager	0.78	53,780	0.025	2,500	0.100	10,030			0.250	16,250	0.40	25,000
3S Asst. Program Director	1.00	62,294	0.329	19,905			0.470	29,236	0.210	13,063		
4S Supervising Professional	1.50	93,306	0.175	10,886			0.325	20,216	1.000	62,204		
5S Psychiatrist	0.10	22,000									0.10	22,000
7S N.P., Psych N.,N.A., R.N.- MA	0.50	60,000			0.500	60,000						
8S R.N. - Non Masters	1.00	70,266			1.000	70,266						
9S L.P.N.	3.20	130,134			3.200	130,134						
11S Occupational Therapist	0.00	0										
21S Psychologist - Doctorate	0.00	0										
22S Clinician-(formerly Psych.Masters)(UFR Title 1:	1.00	53,500									1.00	53,500
23S Social Worker - L.I.C.S.W.	6.83	367,830	2.175	117,037			3.200	172,589	1.450	78,204		
24S Social Worker - L.C.S.W., L.S.W	0.00	0										
25S Licensed Counselor	0.00	0										
26S Cert. Voc. Rehab. Counselor	0.00	0										
28S Counselor	0.00	0										
29S Case Worker / Manager - Masters	1.00	54,139			1.000	54,139						
30S Case Worker / Manager	0.00	0										
31S Direct Care / Prog. Staff Superv.	0.00	0										
32S Direct Care / Prog. Staff III	0.00	0										
33S Direct Care / Prog. Staff II	6.90	226,324	0.600	22,051	4.200	127,096	0.400	14,700	1.700	62,477		
34S Direct Care / Prog. Staff I	0.00	0										
35/36S Prog. Sec/Clerical/Maint./H-GmdsKeep.	0.75	23,772	0.250	7,924	0.500	15,848						
38S Dir.Care O.T., Shift Differential & Relief	XXXXXX	0	XXXXXX		XXXXXX		XXXXXX		XXXXXX		XXXXXX	
39S **Total Direct Program Staff**	25.30	1,277,626	3.625	187,503	10.750	486,334	4.515	247,316	4.660	236,923	1.75	119,750
2E Chief Executive Officer	0.00	0										
3E Chief Financial Officer	0.00	0										
4E Acctng/Clerical/Support	0.50	22,500									0.50	22,500
5E Admin Maint/House-Gmdskeeping	0.00	0										
6E **Total Admin Employee FTE/Exp.**	0.50	22,500	0.000	0	0.000	0	0.000	0	0.000	0	0.50	22,500
7E Commercial Products & Svs/Mktng	0.00	0										
8E **Total FTE/Salary/Wages**	25.80	1,300,326	3.625	187,503	10.750	486,334	4.515	247,316	4.660	236,923	2.25	142,250
9E Payroll Taxes 150		83,046				53861		32,382		17,003		
10E Fringe Benefits 151		214,011				56957		58,626		30,784		67,644
11E Accrual Adjustments		0										
12E **Total Employee Compensation & Rel. Exp.**		1,597,383		187,503		576,952		338,324		284,710		209,894
13E Facility and Prog. Equip.Expenses 390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
14E Facility & Prog. Equip. Depreciation 301				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
15E Facility Operation/Maint./Furn.390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
16E Facility General Liability Insurance 390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
17E **Total Occupancy - Allocated**		138,740		Expense		138,740		Dollars		Dollars		Dollars
18E Direct Care Consultant 201		92,900										92,900
19E Temporary Help 202		7,500				7,500						
20E Clients and Caregivers Reimb./Stipends 203						0		0		0		0
21E Subcontracted Direct Care 206												
22E Staff Training 204		8,808				7,658		863		288		0
23E Staff Mileage / Travel 205		11,160				5,040		4,590		1,530		0
24E Meals 207		14,126				14,126						0
25E Client Transportation 208						0						0
26E Vehicle Expenses 208						0						0
27E Vehicle Depreciation 208						0						0
28E Incidental Medical /Medicine/Pharmacy 209		1,800				1,800						0
29E Client Personal Allowances 211						0						0
30E Provision Material Goods/Svs./Benefits 212						0						0
31E Direct Client Wages 214						0						0
32E Other Commercial Prod. & Svs. 214						0						0
33E Program Supplies & Materials 215		11,000				8,000		3,750		1,250		0
34E Non Charitable Expenses						0						0
35E Other Expense						0						0
36E **Total Other Program Expense**		147,294		0		42,124		9,203		3,068		92,900
42E Other Professional Fees 410		21,500				0		0		0		21,500
43E Leased Office/Program Office Equip.410,390						0		0		0		0
44E Office Equipment Depreciation 410						0		0		0		0
48E Program Support 216		28,800				18,204		7,947		2,649		0
51E **Total Direct Administrative Expense**		50,300		0		18,204		7,947		2,649		21,500
52E Admin (M&G) Reporting Center Allocation		226,647				79,820		61,117		31,645		54,065
53E **Total Reimbursable Expense**		2,160,364		187,503		855,840		416,591		322,072		378,359
54E Direct State/Federal Non-Reimbursable Exp.						0		0		0		0
55E Allocation of State/Fed Non-Reimbursable Exp.						0		0		0		0
56E **TOTAL EXPENSE**		2,160,364		187,503		855,840		416,591		322,072		378,359

ATTACHMENT 7: PRIVATIZATION LAW ASSURANCES

Appendix X: Organizational Commitments Pursuant to Massachusetts Privatization Law

Under Massachusetts' Privatization Law (M.G.L. c. 7 §§ 52, 53, 54, and 55), a successful bidder must:

(i) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:

1. provided ESP services; and
2. were terminated as a result of DMH ceasing to provide such ESP services;

(ii) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees; the Commonwealth currently contributes 80% of the cost of health insurance DMH employees.

(iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate as determined by the state pursuant to M.G.L. c. 7 §54 (2) for those positions for which the duties are substantially similar to the duties performed by regular agency employees;

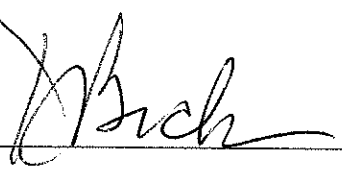
(iv) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons; and

(v) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

In addition, a successful bidder must certify in writing to the state that both the organization and its supervisory employees, while in the employ of the successful bidder, have "no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest."

Name of Organization: Boston Medical Center

I hereby acknowledge that if the organization listed above is chosen to provide ESP services in the Southeast region of Massachusetts, the organization must implement the relevant provisions of the state's Privatization Law referenced above.

Signature: 

Name and Title (please type or print): David Beck, Vice President & General Counsel & Clerk

Date: September 3, 2015

Letters of Support

August 11, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

Justice Resource Institute (JRI) is pleased to support the proposal of Boston Medical Center Psychiatry, with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

JRI has multiple residential and community-based services throughout the Southeastern region of Massachusetts. These include adolescent therapeutic residential schools (Swansea Wood School & Meadowridge Academy), outpatient clinics in Taunton and Attleboro, a STARR program, the Lindencroft group home for girls, a CBAT, the DCF/DMH Caring Together Continuum, and the Cape and Islands CSA (the CBHI network) that provides extensive community-based services serving hundreds of families. We have worked for many years with the DMH ESPs in the area, and have developed strong relationships with them.

The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC proposes the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center
- 24/7 access to board-certified BMC adult and child psychiatrists
- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth

- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Southeast Region.

Sincerely,

Andy Pond, LICSW
President and CEO

Get Connected GW Stay Connected

GROWTHWAYS, INC.
Community Supports for People with Developmental Disabilities
41 North Pearl Street, Brockton, MA 02301 (508) 941-6505 fax 583-7651

August 19, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802

Dear Dr. Buczek:

Growthways, Inc. is pleased to support the proposal of Boston Medical Center Psychiatry, along with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

Growthways, Inc. is a non-profit organization that provides education, training, advocacy, and support services to people with intellectual/developmental disabilities and their families in the Greater Brockton Area. We provide a variety of services which include: residential and independent living programs as well as placement services. We currently provide residential services to 80 individuals. Our organization is dedicated to providing quality services where individuals are supported and empowered to be valued, contributing members of their community.

We are familiar with the programs operated by the team submitting this proposal. The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs, while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC is proposing the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center
- 24/7 access to board-certified BMC adult and child psychiatrists

- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth
- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Greater Brockton Area.

Sincerely,

Marty Berliner
President & CEO

141 Park Street
Attleboro, MA 02703
T 508 226-1445
F 508 226-1476
www.arcnbc.org

August 19, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

The Arc of Bristol County, Inc. is pleased to support the proposal of Boston Medical Center Psychiatry, with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

The Arc of Bristol County began in 1959 as a grassroots organization of parents whose children had mental retardation. Families who once believed they were alone found support and fellowship among other families facing the same challenges. It is an organization with a track record of 52 years, helping people with intellectual and developmental disabilities to gain many of the rights afforded by citizenship. They work, they own homes, and they contribute to the rich diversity of their community. The Arc's advocacy, research, programming and outreach have played a pivotal role in these advances. Today, The Arc of Bristol County provides a wide array of supportive services to over 2,000 children and adults with intellectual and developmental disabilities, and their families, helping them to maximize their talents and abilities, develop independent living skills, and participate as contributing citizens of their communities.

The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC proposes the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center

- 24/7 access to board-certified BMC adult and child psychiatrists
- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth
- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Southeast Region.

Sincerely,

Michael Andrade
President and CEO

National Alliance on Mental Illness
Massachusetts

September 9, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

On behalf of NAMI Massachusetts, I am pleased to write this letter offering my strong support of your proposal to provide emergency services in four catchment areas in the Southeast Region of Boston.

NAMI Mass is a nonprofit agency dedicated to supporting both people with mental illnesses and their families. As Executive Director, I am well aware of our longstanding affiliation with BMC. We have partnered together on many initiatives, including the Boston Emergency Services Program, the Cambridge/Somerville Emergency Services Program, the Metro Boston Recovery Learning Community and the Southeast Recovery Learning Community Program. For the current proposal, I understand that you hope to include NAMI Mass members on your advisory committees, as well as work with them directly to provide crisis services to families and individuals in the Southeast area. I believe that our organization is well positioned to assist in these roles; our membership is comprised of individuals living with mental illness, their families and friends, mental health professionals and others who care about people with mental illness.

I am very pleased to lend our organization's support to this project, and look forward to collaborating with BMC on yet another important initiative. I wish you the best of luck during the review process.

Sincerely,

Laurie Martinelli
Executive Director

The National Alliance on Mental Illness of Massachusetts
The Schrafft's Center • 529 Main Street • Suite 1M17 • Boston, MA 02129-1125
P: 617.580.8541 F: 617.580.8673 Toll free: 800.370.9085 E-mail: info@namimass.org W: www.namimass.org

the TRANSFORMATION center

August 31, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center
85 E. Newton Street, Room 802
Boston, MA 02118

Dear Dr. Buczek:

On behalf of the Transformation Center, I support your bid(s) to lead the Cape and the Islands, Taunton/Attleboro, Fall River, and Brockton Emergency Services Program(s).

As you know, The Transformation Center is one of the first mental health and trauma recovery-oriented organizations in Massachusetts and is recognized as a national leader in trauma informed peer support and training. Our organizational mission is that people –with all our vulnerabilities and strengths, live in communities where people help each other with mutual respect and compassion to overcome the challenges in life. We promote the growth and voices of people with lived experience of mental health, substance use and trauma so that they may find their unique paths to healing and recovery, and so that they may impact and transform policy and practice.

Your proposed emergency services program(s) will meet critical service needs for members of the Cape and the Islands, Taunton/Attleboro, Fall River, and Brockton communities. The mobile crisis intervention and community crisis stabilization services that you propose are integral in supporting the recovery of children, families and adults. We are particularly pleased that there will be significant involvement of peer specialists in your Emergency Service Programs.

Please let me know if there is anything else we can do in support of your bids.

Sincerely,

Deborah Delman
Executive Director

Phone: (617) 442-4111
Toll free: (877) 769-7693
VP: (617) 606-7512
FAX: (617) 442-4005

100 Magazine Street
Roxbury, MA 02119
Website: www.transformation-center.org
Email: info@transformation-center.org

Compassion Counseling Services, PC
First, we listen.

488 West Center Street Suite #2
West Bridgewater, MA 02379
Phone: (508)297-0015
Fax: (508)297-1821
www.compassioncounselingservices.com

8/13/15

RE: Letter of support

To Whom It May Concern:

I am writing on behalf Compassion Counseling Services, PC in support of Boston Medical Center Psychiatry, with partners Bay Cove Human Services and Vinfen's proposal for the four Southeast region emergency service program contracts up for bid. I have direct experience working for and with the BayCove UCC/Mobile Crisis Team. I can't imagine a more competent group of experienced and clinically sound professionals taking on these contracts. They continue to bring consistent, high quality, community-based crisis services to the diverse populations in the areas they serve. I have no question they are the best candidate for the job and will be able to effectively use their model to meet the needs of the community and save lives of the individuals in the most need of services. If you have any questions or concerns, you can contact me at (508)297-0015 ext 2

Sincerely,

Erin Bell, LMHC
Psychotherapist/Owner

Housing Assistance Corporation
Cape Cod

NOAH Center

August 24, 2015

Dr. Joanna Buczek, MD
Boston Medical Center
Behavioral Health Services
771 Albany Street #8
Boston, MA 02118

Gene Carey
Vinfen Corp.
1019 Iyannough Road
Hyannis, MA 02601

Dear Dr. Buczek and Mr. Carey:

On behalf of The NOAH Shelter I am thrilled to support your proposal to the Massachusetts Behavioral Health Partnership to become the lead agency for a Cape and Islands Emergency Services Team.

The NOAH Shelter, and Vinfen have collaborated on several community projects, such as The Operational Task force , The Day Center Steering Committee and the Twelve Step Facilitation Program. BMC is well-known as a leader in emergency services in the Boston community, and we are proud to work with you.
The NOAH Shelter and Vinfen have a longstanding partnership. We look forward to working to support your expanded role in this area. It has long been acknowledged that there were additional strengths you could bring to this crucial area of services

Your proposed program will increase the availability of critical services for individuals and families, especially mobile services. We are pleased that our clients will benefit from the expertise Boston Medical Center has developed by leading the existing BEST program.

Respectfully yours,

Greg Bar
NOAH Director
[Signature]

live learn work grow

Town of Barnstable
Police Department

Paul B. MacDonald, Chief of Police
Sean E. Balcom, Deputy Chief of Police
Matthew K. Sonnabend, Deputy Chief of Police

P.O. Box B
Hyannis, MA 02601

Main Number: 508-775-0387
Main Fax: 508-790-4167
Administration: 508-775-0920
Admin. Fax: 508-790-6317
www.barnstablepolice.com

August 20, 2015

Dr. Joanna Buczek, MD
Boston Medical Center
Behavioral Health Services
771 Albany Street #8
Boston, MA 02118

Gene Carey
Vinfen Corp.
1019 Iyannough Rd.
Hyannis, MA 02601

Dear Dr. Buczek and Mr. Carey:

On behalf of the Barnstable Police Department, I am thrilled to support your proposal to the Massachusetts Behavioral Health Partnership to become the lead agency for a Cape and Islands Emergency Service Team.

Barnstable Police Department and Vinfen have collaborated on several community projects, such as Homeless Outreach and the Community Crisis Intervention Team. BMC is well-known as a leader in emergency services in the Boston community, and we are proud to work with you.

The Barnstable Police Department and Vinfen have a longstanding partnership. We look forward to working to support your expanded role in this area. It has long been acknowledged that there were additional strengths you could bring to this crucial area of services.

Your proposed program will increase the availability of critical services for individuals and families, especially mobile services. We are pleased that our citizens will benefit from the expertise Boston Medical Center has developed by leading the existing BEST program.

Respectfully yours,

Paul B. MacDonald
Chief of Police

Duffy Health Center

94 Main Street
Hyannis, MA 02601
(508) 771-7517
(508) 771-7514, fax
www.duffyhealthcenter.org

August 24, 2015

Dr. Joanna Buczek, MD
Boston Medical Center
Behavioral Health Services
771 Albany Street #8
Boston, MA 02118

Gene Carey
Vinfen Corp.
1019 Iyannough Road
Hyannis, MA 02601

Dear Dr. Buczek and Mr. Carey:

On behalf of Duffy Health Center I am thrilled to support your proposal to the Massachusetts Behavioral Health Partnership to become the lead agency for a Cape and Islands Emergency Services Team.

Duffy Health Center, Vinfen and Boston Medical Center (BMC) have collaborated on several community projects, such as Homeless Outreach and the Community Crisis Intervention Team. BMC is well-known as a leader in emergency services in the Boston community, and we are proud to work with you.

Duffy Health Center and Vinfen have a longstanding partnership. We look forward to working to support your expanded role in this area of behavioral health services.

Your proposed program will increase the availability of critical services for individuals and families, especially mobile services. We are pleased that our clients will benefit from the expertise you have developed by leading the existing BEST program.

Respectfully yours,

Heidi P. Nelson

Heidi Nelson

CEO

Riverside Community Care

THE HELP YOU NEED CLOSE TO HOME

September 8, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802

Dear Dr. Buczek:

Riverside Trauma Center is pleased to support the proposal of Boston Medical Center Psychiatry, with partners Bay Cove Human Services, Inc. and Vinfen, to operate the Cape and Islands Region Emergency Services Programs currently operated by the Department of Mental Health.

As you know, Riverside Trauma Center offers support services, including grief counseling and referrals to help people after critical incidents and respond on-site by helping individuals identify healthy coping strategies. Riverside Trauma Center also coordinates the statewide Riverside-Massachusetts Trauma Response Network. Our role is to respond to disasters and traumatic events throughout Massachusetts. We partner with the Commonwealth and FEMA to implement community disaster recovery plans. We also train and partner with other organizations to develop locally-based response teams. Riverside Trauma Center provides support, consultation, training, and screening to communities when there is a suicide death and also to communities that want to proactively work towards prevention. In these capacities, The Riverside Trauma Center has on multiple occasions provided its DPH-funded suicide postvention services to the island of Nantucket, as well as certain Cape Cod towns.

I am impressed by the creativity and thoroughness of the plan you describe for providing emergency services for the Cape and Islands, and would be glad to collaborating with the BMC team in providing responsive and effective services to the residents of the Cape and Islands region, should your program be selected to provide services in that region.

With best regards,

Larry Berkowitz, Ed.D.
Director, Riverside Trauma Center

Riverside Trauma Center
255 Highland Avenue • Needham, MA 02494 • Tel 781·433·0672 • Fax 781·559·3096
24-Hour Critical Incident Response: 888·851·2451
www.riversidecc.org

Massachusetts Behavioral Health Partnership (MBHP)
Emergency Services Program (ESP) RFR

Organization name: Boston Medical Center

Proposed catchment area name:

☑ Fall River

Contact person: Joanna Buczek, MD **Title:** Vice Chair, Psychiatry
Mailing address: 85 East Newton Street, Suite 802
Boston, MA 02118
Telephone number: 617-414-4708 **Fax number:** 617-414-1975
E-mail address: Joanna.Buczek@bmc.org

Proposed subcontractor(s), if any:
Organization name: Bay Cove Human Services
Contact person: Nancy Mahan **Title:** Senior Vice President, Program Services
Mailing address: 66 Canal Street
Boston, MA 02114

Telephone number: 617-371-3004 **Fax number:** 617-371-3100
E-mail address: nmahan@baycove.org

Organization name: Vinfen
Contact person: Bruce L. Bird, MD **Title:** President and CEO
Mailing address: 950 Cambridge Street
Cambridge, MA 02141

Telephone number: 617-441-1800 **Fax number:** 617-441-1858
E-mail address: birdb@vinfen.org

Service component(s) for which the bidder proposes to subcontract to the above:

Boston Medical Center is providing the following services in collaboration with Bay Cove Human Services and Vinfen:

☑ Child Mobile Crisis Intervention
☑ Adult Mobile Crisis Intervention
☑ Community-based location
☑ Adult Community Crisis Stabilization (CCS)
_ Other: (specify) _____

BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

The primary teaching affiliate of the Boston University School of Medicine.

September 11, 2015

Shelley Baer, M.S.
Director of Emergency Services
Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118-5002

Dear Ms. Baer:

The Boston Medical Center (BMC) Department of Psychiatry is pleased to submit this proposal for the Emergency Services Program (ESP) Contract for the Fall River Area. Key partners (sub-contractors) in this bid include Vinfen (V) and Bay Cove Human Services (BCHS), two premier community agencies who have successfully partnered with BMC in the Southeast and MetroBoston communities to provide emergency service programs and recovery services. These agencies have extensive knowledge and experience in delivering high quality, community-based and recovery-oriented crisis assessment, treatment intervention and stabilization services.

BMC proposes to lead a partnership for revitalization of the Fall River Emergency Service Program in which BMC, in conjunction with BCHS, will provide mobile crisis intervention services and urgent care and BMC, in conjunction with V, will provide community crisis stabilization services for these communities. BCHS will also provide technical support in connection with the electronic medical record that will be used by the Fall River ESP.

BMC will provide seasoned clinical leadership, comprehensive program administration, and BEST program technology to assure a revitalized and robust Fall River Emergency Service Program (FR ESP). The medical and clinical infrastructure of the proposed FR ESP is designed to assure that BMC psychiatry has direct involvement in all of the services and a substantive knowledge and oversight of the clinical work overall.

These partners have more than 100 years of experience and considerable competencies in the treatment of complex mental health and substance abuse conditions to meet the needs of culturally diverse children, families, adults, allied providers and community stakeholders. Our proposed model incorporates not only the best practice features of a comprehensive emergency services program as referenced above, but also important philosophical, policy and program practices designed to assure that the FR ESP is focused first and last on the individuals who need our care in psychiatric and social emergencies. These include:

- A FR ESP culture founded on recovery, embracing inclusion rather than extrusion, and diversion, with a robust family partner and consumer provider involvement in the design, oversight and delivery of ESP services;

BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

The primary teaching affiliate of the Boston University School of Medicine.

- Alliances with key providers, consumers, families and state agency stakeholders, designed to make navigation across the system, even in crisis, a seamless experience;
- Immediate access to clinical, medical and social information about clients to guide differential diagnosis and intervention choices. This also serves to strengthen what may be frayed linkages to caregivers and/or programs to address treatment adherence and assure continuity of appropriate care;
- Discrete services tailored to the distinct needs of children and youth, and to the family and community contexts in which they live, informed by *Systems of Care* (SOC) philosophy and practices;
- Services are organized to respond to members of the diverse racial, ethnic, and linguistic communities that comprise the Fall River communities, recognizing both the risk of disparities in access to effective care for racial, ethnic, linguistic and cultural minorities, and the significance of culture to the effective treatment of mental health and substance abuse conditions;
- Stakeholder input, as demonstrated by engagement of the Southeast Recovery Learning Community, NAMI MA, JRI, ARC of Bristol County, Gateways, Transformation Center and Compassion Counseling in the preparation of the proposal; and
- Intersystem planning, addressing the complex social, medical and behavioral health needs of our target client population, which are typically met through a diverse, and sometimes not well integrated, array of services in the community.

BMC and its partners are excited by the prospect of putting together our longstanding commitment to high performing emergency services, our clinical and administrative competencies, and the assets of our partners to provide residents of the Fall River area with a revitalized ESP. We have also submitted proposals for the Taunton/Attleboro, Cape Cod and the Islands and Brockton ESPs. We believe that BMC, in conjunction with BCHS and V, have the capacity and expertise to undertake this considerable effort. We also believe that serving multiple catchment areas would provide opportunities for the programs to benefit from economies of scale, in sharing resources (especially during periods of high demand), from standardization of communications and practices and in enhancing access and continuity of care.

Thank you for the opportunity to reply to the solicitation and please do not hesitate to call on us for any questions you may have.

Sincerely,

Joanna Buczek, MD
Interim Boston University School of Medicine Chair
Boston Medical Center Chief of Psychiatry

Acronym Keys

ACO-Accountable Care Organizations
ALP-Alternative Lock-Up Program
ASL-American Sign Language
B-Brockton
BAMSI-Brockton Area Multi-Services, Inc.
BC-Bay Cove Human Services
BCBA-Board Certified Behavior Analyst
B-ESP-Brockton Emergency Service Program
BEST-Boston Emergency Service Team
BHS-Behavioral Health Services
BMC- Boston Medical Center
BMC-ESP-Boston Medical Center Emergency Service Program
BRC-Boston Resource Center
CARF-Commission on Accreditation of Rehabilitation Facilities
CBFS-Community Based Flexible Supports
CBHI-Children's Behavioral Health Initiative
CBL-Community Based Location
CCI-Cape Cod & Islands
CCI-ESP-Cape Cod & the Islands Emergency Service Program
CCS-Community Crisis Stabilization
CFT-Child Focused Team
CORD-Cape Cod Organization for Rights of the Disabled
CPRP- Certification for Psychiatric Rehabilitation
CPS-Certified Peer Specialist
CSA-Community Service Agency
CS-ESP-Cambridge Somerville Emergency Service Program
DBSA-Depression Bipolar Support Alliance
DCF-Department of Children & Families
DDS-Department of Developmental Services
DET-Department of Employment & Training
DMH-Department of Mental Health
DoP- Department of Psychiatry
DPH-Department of Public Health
DYS-Department of Youth Services
EATS-Enhanced Addiction Treatment Service
ED-Emergency Department
EMR-Electronic Medical Record
ESP-Emergency Service Program
FR-Fall River
FR-ESP-Fall River Emergency Service Program
FTE-Full Time Employees
ICC-Intensive Care Coordinator
IHBT-Intensive Home-Based Treatment
IHT-In-Home Therapy

IOP-Intensive Outpatient Programs
JRI-Justice Resource Institute
MBRLC-Metro Boston Recovery Learning Community
MCI-Mobile Crisis Intervention
MOR-Milestones of Recovery

MOU-Memorandum of Understanding
NAMI-National Alliance on Mental Illness
PACT-Program for Assertive Community Treatment
PES-Psychiatric Emergency Services
PHP-Partial Hospitalization Program
PI-Performance Improvement
PPAL-Parent Professional Advocacy League
PR-Psychiatric Rehabilitation
PSP-Parent Support Program
QA-Quality Assurance
QI-Quality Improvement
QM-Quality Management
QOLO-Quality of Life Outcomes
RAP-Runaway Assistance Program
RCC-Recovery Connection Centers
RFR-Request for Response
RLC-Recovery Learning Community
SERLC- Southeast Recovery Learning Community
SOAP-Structured Outpatient Addictions Programs
SOC-Systems of Care
STARR-Stabilization, Assessment, and Rapid Reintegration
TA-Taunton Attleboro
TA-ESP-Taunton Attleboro Emergency Service Program
TIP-Transition to Independence Project
TPP-Tenancy Preservation Project
UCC-Urgent Care Center
V-Vinfen
VNA-Visiting Nurse Association
WRAP-Wellness Recovery Action Plan

Narrative Response

1. General Qualifications and Infrastructure

The Boston Medical Center (**BMC**) Department of Psychiatry (DoP) is the bidder for the Emergency Service Program (ESP) Contract for the Fall River (FR) Area. Key partners (sub-contractors) in this bid include Bay Cove Human Services (**BC**), and Vinfen (**V**).

BMC will lead the partnership providing seasoned clinical leadership, comprehensive program administration, and Boston Emergency Service Team (BEST) program technology to assure revitalization of the **Fall River Emergency Service Program (FR-ESP)**. BC and V have considerable experience in collaborating with allied providers and community stakeholders and expertise in providing evidence-based Psychiatric Emergency Services (PES) for the treatment of complex mental health and substance abuse conditions among culturally diverse children, families, and adults.

BMC, in conjunction with BC and V, will also provide urgent care, crisis stabilization, clinical triage, and psychiatry services. BC and V will offer Mobile Crisis Intervention and Community Crisis Stabilization (CCS) for this catchment area. BC's subcontract also includes technical support in connection with the Electronic Medical Record (EMR) that will be used by the FR-ESP.

BMC, BC, and V have longstanding track records of building care partnerships to benefit clients. BMC will leverage its competence in building and maintaining the robust, successful BEST and Cambridge Somerville Emergency Services Program (CS-ESP). Productive alliances with consumers, their families, state agencies, local governments, criminal justice organizations, national and local community and social service agencies, religious and cultural organizations, and behavioral, healthcare, and substance abuse providers are a requisite for an effective, integrated, and seamless experience for clients. To that end, BMC is partnering with BC and V – two major providers with clinical expertise and a breadth of experience in developing community programs and collaborations.

1.1 Licensure

1.1.1 Department of Public Health (DPH)-Licensed Outpatient Mental Health Clinic: **BMC/BC/V**: Yes/Yes/Yes

1.1.2 Licensed as a Hospital

1.1.2.1 DPH: Yes/No/No 1.1.2.2 Department of Mental Health (DMH): No/No/No

1.2 Accreditation

1.2.1 National Organization: Yes/Yes/Yes ***1.2.2*** Joint Commission/Commission on Accreditation of Rehabilitation Facilities (CARF) /CARF

1.3 Currently Contracted MassHealth Provider/Applicant Yes/Yes/Yes

1.4 Three Years of Experience Providing Behavioral Health Services (BHS) to Wide Range of Populations Yes/Yes/Yes

1.4.1 # Years Providing Behavioral Health Services to Children, Adolescents, and Families: 31+/12/20

1.4.1.1 # Youth Served CY14: BMC: 9,944 encounters for clinic and ESP combined; BC: 2,169 BEST, 1,113 Early Inter., 300 Family Support Center, 100 Parent Support Program (PSP); V: 300

1.4.2 # Years Providing Behavioral Health Services to Adults: 31/42/38

1.4.2.1 # Adults Served in CY14: BMC: 53,134 encounters for clinic and ESP combined; BC: 1,990; V: 100 programs and 6263 people served; 238 young adults and adults Cape Cod CCS; 2,792 adults Community Based Flexible Supports (CBFS); 166 Program for Assertive

Community Treatment (PACT); 279 homeless services; 1,575 Clubhouse; 108 Recovery Learning Centers; 929 Clinical/Outpatient services.

1.4.3 Behavioral Health Services Provided and Populations Served: BMC provides BHS to children and adults, including emergency psychiatric services, outpatient BHS, consultation and liaison services, peer support and recovery services, refugee mental health services, and disaster mental health counseling services. BMC has: been the lead agency in BEST for the past 12 years; participated in the BEST Program as a Designated Emergency Department (ED) since 1995; and been the lead agency for the CS-ESP for six years. BMC's DoP is organized to respond to a racially, ethnically, and linguistically diverse, urban population who faces complex addictions and an array of psychiatric and health conditions.

BC operates eight CBFS teams; a specialized outreach team; a Housing First program (Home At Last); three Clubhouse programs; PACT; Day Treatment; Tenancy Preservation Project (TPP); two specialized residences providing treatment for 12 men with mental illness and problematic sexual behaviors and a former Quarterway residence; 40 community residences with partial and 24-hour care; a Mental Health Clinic, providing psychopharmacology and therapy; a DMH transitional shelter, and four CCS programs. BC has long operated specialty residential and clubhouse programs serving Spanish, Vietnamese, Cantonese, and Mandarin speaking adults. Two bi-lingual BC CBFS who represent these cultures work with these populations. BC, as a BEST partner, provides ESP services to both youth and families in the Boston area, while all other services are available to adults only.

V provides community based services to people with psychiatric conditions, intellectual and developmental disabilities, brain injuries, and behavioral health challenges. V's Psychiatric Rehabilitation (PR) Division is dedicated to the recovery of adults and transitional age youth living with psychiatric disabilities, substance addiction, and/or HIV/AIDs throughout eastern Massachusetts. V's outreach-oriented assertive community treatment serves clients via CBFS Services and PACT. V has removed cultural and linguistic barriers to service by recruiting a diverse staff, accessing translators as necessary, respecting and celebrating cultural differences and linking clients to culturally relevant community supports.

1.5 Presence in and Knowledge of the Catchment Area

1.5.1 Current Location: BMC, BC, and V will work in partnership to establish an ESP Community Based Location (CBL) with welcoming signage and accessibility by public transportation. It will be well-advertised to the community and constituencies.. BC and V will also contract with local transportation companies to ease access for clients in crisis. BMC in collaboration with V currently operates RLC programs in the FR area. One of the main Recovery Connection Centers (RCCs) is located in FR. In operating this program, BMC and V have become knowledgeable about the FR community and have established relationships with many key stakeholders including the DMH FR staff, Child and Family Services and SCIL.

1.5.1.1 # of Years Operated in Uninterrupted Physical Location in Catchment Area: 4 years

1.5.1.2 Address of above with Longest Duration: The Empowering Resilience Recovery Connection Center, 66 Troy Street, Fall River, MA was established in 2012 and continues to operate at this site.

1.5.1.3 Rationale for and Plan to Establish a Physical Location: BMC and the V facility and real estate team will prioritize identification of a CBL upon award. V has a proven track record of identifying and locating appropriate program sites in a timely manner by leveraging its strong presence in Southeastern MA and existing relationships with local commercial realtors. V is

already familiar with the FR real estate market and the availability of properties because of their extensive search in the past year for new space for their FR program.

1.5.2 Brief Needs Assessment: Many of the FR-ESP communities have significant community health and mental health services that we will support and access in our efforts to provide emergency services such as but not limited to: Arbour Counseling Services, Fellowship Health Resources, Seven Hills Foundation, Child and Family Services, Solid Ground Psychotherapy Associates, Steppingstone Incorporated, Bay Coast Behavioral, Fall River Psychological Associates, and Riverwood Mental Health Associates.

BMC and V have familiarity with the FR area through their development of recovery learning community services in the area and have become knowledgeable about the needs and strengths of this community. The current FR-ESP has many strengths, yet concerning limitations and gaps need to be effectively addressed in order to ensure that consumers in crisis are responded to in a timely, respectful, and meaningful manner. Historically, the design of the crisis continuum has been designed to be reactive to acute psychiatric emergency issues and not focused on early intervention and prevention. Stakeholders report that the community has for year expressed the concern that the ESP team would not provide MCI services to the client's home, residential program or other human service facilities, and would only evaluate the client at the local ED. Local EDs have been overcrowded by individuals with acute psychiatric and substance abuse problems needing crisis evaluation and treatment. Consumers face long waits which may exacerbate their psychiatric issues and increase the likelihood of hospitalization.

1.5.3 Established Relationships with Stakeholders: BMC, BC, and V are committed to providing early access, upstream interventions, and accessible PES to those in need. Critical to these goals are the development of strong relationships with stakeholders. BC, BMC, and V have longstanding collaborative, collegial, and respectful partnerships with state agencies including DMH, Department of Developmental Services (DDS), Department of Children and Families (DCF), Department of Youth Services (DYS), Department DPH, Department of Employment and Training (DET), MA Commission for the Deaf and Hard of Hearing and MassHealth managed care organizations. BMC and V, in particular, have well-established, effective working relationships with many key FR stakeholders including FR DMH staff and Child and Family Services

V has established, built on, and maintained strong linkages with a variety of community-based resources, including: 1) national and local family support and advocacy groups such as National Alliance on Mental Illness (NAMI); 2) behavioral and other healthcare providers such as Arbour Counseling Services, Seven Hills Foundation, and South Bay Mental Health; 3) substance abuse providers, advocacy groups, self-help and peer groups, and detox facilities such as local AA and NA groups; and 4) homeless providers such as Steppingstone Incorporated.

1.5.4 Interface with Existing Crisis Program: BMC and V staff currently interface with the existing DMH FR ESP staff, collaborating in providing services to shared clients in the FR area.

1.6 Continuum of Care: BMC offers a continuum of complementary programs and services targeted to the unique needs of children, adults, elders and their families in concert with the continuum of BHS offered by BC and V described in section 1.4.3. See Attachment 1.

1.7 Administrative Infrastructure: The BMC DoP leadership team includes: Joanna Buczek, MD, Vice Chair of Psychiatry, BMC; Anna Fitzgerald, MD, Medical Director, PES; Joan Taglieri, MSN, Director, Clinical Operations, Psychiatry and BEST; Sarah Carignan, MBA, Administrative Director, Psychiatry; Marion Burke, MSN, Director of Quality Management (QM) and Training, Psychiatry; Andrea Hall, LICSW, Clinical Director of BEST and CS-ESP,

Tasha Ferguson, LMHC, Assistant Clinical Director and MCI Director; and Cindy Gordon, LICSW, Clinical Director, PES, and Adult Outpatient, Psychiatry. The team is directly involved in the administrative, clinical and financial oversight of the BEST and CS-ESP and will be responsible for the implementation of FR-ESP in partnership with BC and V. BMC, BC and V have considerable experience and competency in behavioral health service delivery, system development/oversight, and delivery of ESPs serving youth and adults.

1.8 Medical and Clinical Infrastructure: BMC's model strives to combine its medical and clinical expertise with the critically important assets and roles of significant providers in the FR community. The medical and clinical infrastructure of the proposed FR-ESP is designed to assure that BMC psychiatry has direct involvement in all of the services and a substantive knowledge of the clinical work overall, coordinating the local capacity and competence to assure the integrity and continuity of care for each child or adult served. Medical and clinical oversight of FR-ESP will be provided through an interrelated committee structure that includes four key elements.

The current ESP Senior Leadership Committee (Buczek, Fitzgerald, Burke, Carignan, Hall, Ferguson, Gordon, and Taglieri) will also serve as the **FR-ESP Senior Leadership Committee** joined by the new FR-ESP Director and MCI Director. In keeping with the BEST/CS-ESP model, the Committee will meet weekly to manage and oversee FR-ESP medical and clinical aspects.

The **FR-ESP Clinical Leadership Committee** will mirror the existing BEST/CS-ESP Clinical Leadership Committee; be comprised of BMC, BC, and V medical and clinical leadership; meet weekly; oversee day-to-day operations, ensure consistency in clinical practice, and manage the system of care; manage quality, including policy and procedure development, compliance with applicable standards, regulations, and utilization review and training.

Based on the BEST and CS-ESP model, the **FR-ESP Advisory Committee**, comprised of key stakeholders, including behavioral health and social service agencies, consumers and family members, child advocacy groups, DCF, DDS and DMH, representatives of special needs citizens and others in the catchment area, will meet quarterly to inform policy issues and practice, and monitor responsiveness and effectiveness of ESP.

The ESP Medical Leadership Committee, is comprised of the ESP Medical Director, CCS Medical Director and all the on-call child and adult Psychiatrists, who provide backup consultation for the Southeast ESP. A monthly meeting of all Psychiatric Nurse Practitioners who provide CCS services includes supervision, training, case review, and consultation.

1.9 QM Infrastructure

1.9.1 Key Staff Positions and Infrastructure Elements: The **Director of QM** is responsible for the development and oversight of a fully-integrated Performance Improvement (PI)/QM plan which ensures the quality, appropriateness, and continual improvement of services provided by the BMC-ESP. S/he also provides Quality Improvement (QI) education and information to all components of BEST. Additionally, the Director identifies and creates reports that provide data by which to measure and evaluate the ESP's compliance with performance standards - some of which have been defined by ESP leadership, and others by payers and regulatory groups.

The **Senior Leadership Committee** (see 1.8) meets weekly, functions as the executive group, and oversees the QM Program including: QI activity prioritization; PI activity initiation, oversight, coordination; report review; and approval of PI teams' recommendations. One to two of the monthly meetings also include the Medical Directors of BMC PES and partner designated

EDs, the ESP Assistant Clinical Director/Youth MCI Program Director, and Urgent Care Center (UCC) Managers—the **QM Committee.**

The Clinical Leadership Committee, see 1.8 above, will serve as the **QM Committee** and: 1) establish expectations and performance standards; 2) review volume, activity, and utilization data to identify high-user clients, diversionary and hospitalization rates, barriers to accessing service, etc.; 3) identify opportunities for improvement; make QI/PI recommendations to Senior Management Team; 4) manage the PI process and ensure its implementation to measure, assess and improve performance; 5) resolve problems/complaints that could adversely affect service delivery; and 6) survey stakeholders, review results and identify target areas for improvement.

The FR-ESP **Advisory** Committee, which will meet bi-monthly to inform QM Committee's work, will be comprised of internal and external stakeholders, e.g. the School Department, Police Department, the Parent Professional Advocacy League (PPAL), Mental Health Court Programs, consumers of mental health services, representatives of homeless shelters and services, DMH, DDS, DSS, DYS, and key community providers.

1.9.2 Current QM Plan: See Attachment 2.

1.9.3 QM Tools and Strategies: The BMC-ESP QM Program focuses on both Quality Assurance (QA) and QI. **QI** examines existing work methods, processes and systems, and develops ways to make them better. Rather than solely problem-based, QI assumes that opportunities for improvement always exist. **QA** seeks to answer the question: what do you do and how do you know you're doing it well? Therefore, each component of BEST considers: 1) the most important aspect(s) of your work, the most important things that you do, and why you are here; 2) how do you know that you're doing those things well/correctly, objective data or information that informs that conclusion; and 3) how those data are collected, how often the data is examined, performance standard (percentage or numeric) set for your service. In addition to each component of the service creating indicators of quality, BEST identifies aspects of its work which are high risk, high volume, or problematic. QA and QI activities and teams may be organized to address these issues; they may be also be referred to existing committees for exploration and problem solving.

1.9.4 Data and Information Use: BMC ESP created a web-based EMR into which all encounters are entered and with 40 standing data reports that pull information from client records and encounters. All users can easily see information for any time period and special reports can be requested and quickly generated. Clinicians and Managers can access information and track various aspects of their performance on a weekly and monthly basis. Reports include volume flow by time of day and week, allowing appropriate allocation of resources to meet the changing demand. ESP leadership teams regularly review reports in order to track the program's compliance with performance standards and inform development and improvement decision-making. A detailed description of how various data are used is found in Attachment 2.

2. ESP Core Competencies

2.1 Crisis Services

2.1.1 Experience: The contractor and sub-contractors have extensive track records and staff members with long tenure and experience in providing crisis services:

- For more than 12 years, BMC has held the contract with MBHP for BEST and has been a sub-contracted designated ED for BEST since 1995. BMC has held the contract with MBHP for Cambridge/Somerville ESP for more than six years;
- BC has been a BEST sub-contractor for more than 12 years, providing mobile services to Boston's largest, central neighborhoods;
- V operated a crisis unit under BEST prior to 2004 and currently operates one for CCI-ESP.

2.1.2 Success

2.1.2.1 Response Time: BMC has focused on response time as a quality measure with its current ESPs. Please see Attachment 3 for more detailed information.

2.1.2.2 Variable Demand: Please see Attachment 3 for more detailed information.

2.1.2.3 Staff: BMC has had great success attracting leaders and Clinicians with many years of direct experience working as crisis Clinicians, as well as in providing mental health services to all ages in a variety of community settings. Please see Attachment 3 for more detailed information.

2.2 Mobile Services

2.2.1 Experience: Under current BMC ESP contracts, Clinicians have made 33,291 initial evaluation visits to community sites, *excluding hospitals, ESP UCCs and CBLs,* since 2003. Community sites include homes, DMH and DDS group homes, DYS facilities, DCF residential programs, nursing homes, shelters, detox programs, schools, police stations, court clinics, Logan Airport, subway stations, on the street, in primary care/clinic offices, elder service agencies, and in community centers (e.g., boys and girls clubs). For the year ending May 15, 2015, the BEST BC team performed 61.45% of youth and 57.20% of adult evaluations outside of EDs. The number of evaluations in the community was 3,118, excluding follow-up visits. All populations who call the 800# are served by mobile teams, unless there are considerations of dangerousness or imminent risk for self-harm or harm to others; in these cases, BEST facilitates safe transport to a designated ED for evaluation and containment. Home visits are conducted 24/7 for youth and adults on a case-by-case basis, exceeding MBHP ESP performance specifications. Partner agencies BC and V have decades of experience providing community-based services involving outreach and comfort in meeting clients outside of formal settings.

2.2.2 Implementing Strategies to Create a Revitalized Culture: The ESP triage and mobile Clinicians are clear from the time of orientation that the mission is to respond to persons where they are evidencing need or distress. Evaluations in the person's home (or other familiar setting) provide the richest picture of the person's whole self, the context of the crisis (what's happening in his/her environment), and other variables that may help or hinder access to care. Because of the value placed on such practice, staff report high satisfaction with the quality of the service they provide on behalf of youth and adults. In 2015, BC mobile Clinicians completed 987 initial encounters at *private* homes, not including follow-up visits. Staff are trained to understand that people can suffer iatrogenic illness when using 911 ambulances and high stress EDs. People brought into EDs by Section 12 report feelings of coercion, especially when Section 12 may not have been indicated. A frail elder seen in the ED can look far more functional and capable of caring for oneself than during a home visit involving direct observation of self-care, availability of provisions, and general safety of the environment.

These themes are stressed both in training staff and in making community presentations to stakeholders about the value of community-based interventions. Other topics include how the community site offers the opportunity to join with the individual and his or her collaterals and the economies, in time and dollars, achieved outside the ED venue. Relationships with Accountable Care Organizations (ACOs) will stress the common goal of providing coordinated intervention "upstream" in the arc of a crisis, reducing reliance on high-cost EDs.

2.2.3 Overcoming Challenges to Creating a Revitalized Culture: In FR-ESP, we anticipate using our integrated BMC/BC partnership to build a well-resourced mobile team with the experience and competencies to win the confidence and trust of stakeholders. The biggest challenge is carrying the message about mobile crisis to potential users and referral sources. Based upon preliminary conversations with agencies and vendors, mobile and CBL evaluations are viewed as a positive alternative to hospital settings and welcomed in many instances.

A challenge in the Fall River area will be introducing clients to a new site, given that the DMH site presently used for CBL will not be available for the next ESP provider. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients in crisis who present at the current FR site are triaged with the ESP and not referred to an ED.

Outreach efforts to community entities will include: presentations/discussion on process and goals of MCIs (See Attachment 4 for a training tool BEST currently uses); setting realistic expectations of what mobile interventions can achieve; and establishing a feedback loop for entities to share experiences with ESP leadership for QI.

2.2.4 Experience with Community Behavioral Health System for Youth and Families: Since 2009, BMC and sub-contractor BC have been committed to the delivery of MCI services utilizing the Ten Principles of the Wrap-Around Process as a guiding philosophy shared by the other CBHI services. A high priority is placed on providing MCI services in the least-restrictive community setting, and on collaborating closely with the family's providers and supports of choice. Outreach to share information on MCI and to encourage collaborative, early intervention is regularly and routinely made to community entities. Problems and barriers are identified and addressed through initiating system-wide dialogue and planning. The goal of such efforts is to assist in stabilizing and supporting youth to be maintained in the community in conjunction with their existing behavioral health providers and natural supports.

2.3 Diversion

2.3.1 ED Diversion

2.3.1.1 Experience and Strategies: From July 2003 to Dec. 2008, in a catchment area with nine major hospitals with EDs, BMC's BEST performed just under 14,000 (2,545 annually) adult and child community evaluations, or 28% of its total encounters. From Jan. 2009 to June 2015, that number grew to 33,181 (5,105 annually) initial community evaluations, or 31.2% of total encounters. Volume includes providing commercial evaluations in a busy ED; therefore, MBHP data for public payers would show a higher percentage of community evaluations.

In FR-ESP the percentage of community evaluations for youth indicates the DMH MCI team has had success in providing mobile intervention for the MCI population. BC has demonstrated ability to exceed the standard of 60% MCI intervention in the community and would maintain and hopefully improve this measure in the subject catchment area. In addition, BEST as a whole currently sees 27% of all adults in the community.

BMC and BC would seek to build on the current DMH team's success in providing adult interventions in the community and, in addition, would aim to decrease the current high rate of

inpatient hospitalization of adults. A challenge in the Fall River area will be introducing clients to a new site, given that the DMH site presently used for CBL and CCS will not be available. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients who present at Dr. John C. Corrigan Mental Health Center in crisis are triaged with the ESP and not referred to an ED.

Strategies employed to date by BMC/BC: 1) 800# Call Center master's level Clinicians assess every case for opportunity to conduct the evaluation in the community; only those cases in which acute risk to self or others is present and cases involving potentially acute medical issues are transferred to an ED; 2) BEST continues to do significant outreach to schools, behavioral health providers, primary care clinics, shelters, housing agencies, Visiting Nurse Association (VNAs), police, and many others, promoting the value of community-based evaluations; 3) By working with the Boston Police and EMS, BEST police co-responders and BEST 800# have diverted more than 500 people from "automatic" ED visits since August 2011 by offering on-site and telephonic clinical support for first responders; many of these diversions did not require a full ESP evaluation and are therefore not reflected in BEST MBHP data reports; 4) Regular engagement in crisis and risk management planning with clients of Community Service Agency (CSAs), DMH, DCF, DDS, DYS, and other entities; and 5) Outreach to ACOs to coordinate "upstream" interventions early in arc of crisis.

2.3.1.2 Strategies to Create Culture: The culture of diversion from EDs is already present in BMC, V and BC, and its development will continue to be nurtured. All leadership firmly believe that in the majority of cases, the best outcomes happen outside of the ED and, more specifically, that community interventions allow for better care coordination. Community-based mobile response is part of the training, orientation and annual performance reviews for staff and trainees. By educating partners, consumers and families about a wide range of community resources, encouraging early intervention, and providing timely, competent crisis response, efforts to move crisis care away from the hospital setting are reinforced. As an example of success, BMC's own ED has been able to reduce youth coming to the ED by 16% for the year ending June 30, 2015, by educating users about the mobile alternative and by "handing" interventions back to the BEST BC mobile team for youth who originally presented at the ED.

2.3.1.3 Strategies to Shift Away from ED: 1) Work with behavioral health and primary care provider networks to steer clients in crisis to the ESP and away from EDs. This would involve encouraging providers to routinely share information about the ESP with their clients, and in particular, to promote on their websites, in their voicemails, and in off-hours consultation the use of the ESP when in crisis; 2) Outreach to major holders of CBHI, DMH, DDS, DCF, and CBHI contracts to form alliances, create Memorandum of Understanding (MOUs), and develop protocols for managing crisis situations that prioritize use of ESP; 3) Outreach to ACOs to develop MOUs for involving the ESP early in the trajectory of a crisis; 4) Work with EDs to identify major sources of referrals to their venues and join with ED leadership in developing alternative strategies with referral sources 5) Further develop crisis planning and risk reviews for persons served by CSAs, DCF, DMH, DDS, and DYS; and 6) Utilize the 800# Call Center to assess every case for the opportunity to conduct the evaluation in the community.

2.3.1.4 Challenges to Create Culture: Strategies to address the following challenges are outlined in 2.3.1.1 and 2.3.1.3 above. Challenges include difficulty transforming long-held practices in a community that relies heavily upon ED resources; addressing referring professionals' personal and agency liability concerns; and lack of education regarding efficacy and benefits of community-based interventions.

2.3.2 ED-Specific Diversion Plans

2.3.2.1 Collaboration with Hospital: See Attachment 5 (including 2.3.2.1.1, 2.3.2.1.2, 2.3.2.1.3, 2.3.2.1.4, 2.3.2.1.4.1) for collaboration plans/existing agreements. Outreach has been made to St. Anne's Hospital, and efforts are continuing to collaborate with Corrigan Mental Health Center and Charlton Memorial Hospital.

2.3.3 Diversion from Unnecessary Psychiatric Hospitalization and Other Placement

2.3.3.1 Experience: BMC's BEST has a strong history in diverting clients from inpatient psychiatric hospitalization. For the year ending June 30, 2015, BEST overall diverted 69% of clients evaluated to other, less restrictive resources. Six of nine hospitals in BEST's current ESP area screen all psychiatric cases before contacting BEST; therefore, the cases referred to BEST represent the most acute presentations and are less likely to be diverted from hospitalization. This contributes to BEST's overall hospitalization rate being somewhat inflated. BEST BC's adult hospitalization rate is 24.33% for the year ending June 30, 2015. Despite a high acuity in the population seen, BC has kept youth inpatient hospitalization rate to 22.69%. BMC's own designated ED has kept youth hospitalization rate to 17.71% for the year ending May 31, 2015.

BEST uses urgent psychopharmacology and accelerated intakes via its partners' outpatient departments, to intervene quickly and lower the risk of out-of-home placement. BEST utilizes other community-based interventions to the extent these are accessible; the ESP's own CCS programs; structured outpatient addictions programs (SOAP), partial hospitalization program (PHP), in-home therapy (IHT), intensive home-based treatment (IHBT), and intensive outpatient programs (IOP).

2.3.3.2 Strategies to Create Culture and Educate: In the current BEST ESP, BMC has worked to promote a philosophy of recovery using community resources, holding the following principles: 1) Crisis evaluation focuses on engaging patient and family in treatment; 2) Crisis evaluation is not solely triage but also treatment; 3) The best crisis work reveals and utilizes patient's strengths, inspires hope, and meets the patient where he or she is; 4) Hospitalization is more often treatment of last resort; 5) Hospitalization can be regressive, traumatizing, and cost inefficient; 6) Good clinical care may involve taking risks and it is the thoroughness and communication of awareness of risk that protects patients and treaters alike; and 7) Responsibility for care of self and avoidance of risk is shared by the patient, provided he or she is not grossly psychotic or cognitively impaired.

Education of families and providers is important and ongoing. The following methods of working with people in crisis are stressed: offering choices; engaging concentrically for individuals who are scared or threatened; using an easy, non-direct, increasingly deeper process; seeking collateral perspectives; remaining aware of one's own frustration and inevitable potential for projective identification; and sharing and documenting risk.

2.3.3.3 Strategies and Resources to Maximize Use of Diversionary Services: These include offering high-quality, accessible CCS services within the ESP; access to urgent outpatient intakes and psychopharmacological appointments; and seamless coordination with vendors who provide the continuum of services, including the new CBHI levels of care serving youth.

2.3.3.4 Designated ED Model: BMC does not plan to use the designated ED model.

2.4 Recovery-Oriented Services

2.4.1 Hiring Practices

2.4.1.1 Experience: BMC DoP leadership has actively promoted the principles of recovery, resilience, and strength-based treatment for many years in its behavioral health ambulatory service and in its PES. We work with Managers of all of ESP components to develop ways to

facilitate the hiring of Clinicians who share our beliefs in this area and who have experience practicing the principles of recovery and resilience. The orientation and ongoing education of staff includes a focus on recovery and strength-based treatment approach. In 2008, BMC was awarded the contract to be lead agency for the creation of the Metro Boston Recovery Learning Community (MBRLC). In 2012, BMC became the lead agency for the Southeast Recovery Learning Community (SERLC). BMC continues its active lead agency role to maintain and develop services in these RLCs, which work closely with ESP leadership and clinical staff.

The SERLC under the auspices of BMC has a network of five RCCs which are located in Brockton, Taunton, Hyannis, Plymouth, and Fall River. Support groups are also run in the New Bedford community. All five centers are staffed and run entirely by Peers, persons with lived mental health experience. The leadership of SERLC is comprised of five RCC Directors/Coordinators, the SERLC Director, and the SERLC Chair. The leadership team meets bi-weekly to address concerns. The SERLC will work closely with the proposed BMC Southeast ESPs as it helps publicize the program, recruit Peers for employment, and connect individuals served by the ESP to the RCC and the SERLC. The Fall River RCC, located at 66 Troy Street, is open four days per week.

It has long been the practice of BC to recruit highly trained applicants, advertising in language that is recovery oriented in nature, whose experience has been with the mental health recovery movement by way of education, internship and/or past employment. The recovery community has educated universities and job sites where recruits receive training, thereby creating an applicant pool rich in experience with a community-based treatment philosophy. The mobile team has recruited and hired clinical staff with lived experience for a variety of positions both in the ESPs and elsewhere in the agency. This allows for greater understanding and compassion toward the clients served.

V's dedication to helping people recover through state-of-the-art rehab services started in the late 1980s. V is person-centered and has a proven record of positive client outcomes: improved symptom management; increased self-reliance and independence; improved daily living skills and housing stability; reduced hospitalization rates; and progressive improvements in quality of life. V is a founding member of MassPRA, an advocacy organization of clients, providers and funders dedicated to promoting rehab and recovery-focused services. MassPRA's first President was a V leader; and a V leader currently serves on the Board of Directors. In 2006, it began providing fee assistance and training to enable staff to sit for their Certification for Psychiatric Rehabilitation Practitioners (CPRP) exam. Today, it has 55 CPRPs on staff.

2.4.1.2 Recruitment Strategies: BMC's academic partner, Boston University, has a master's degree program in Counseling Psychology which leads to LMHC licensing. The curriculum of this program has a strong focus on recovery. Many students, in the first and second year of their program, do six month-long clinical placements in BEST. BMC has hired many of the graduates of this program into positions within BEST. BEST also provides clinical placements/ internships for students from area schools of social work. These programs have successfully included principles of recovery and strength-based treatment into their curricula. During students' time with us, their knowledge and understanding of recovery is enhanced through hands-on clinical experience and staff training. Upon graduating from their programs, we can select for hire those people who we feel have truly incorporated the recovery philosophy into their practice.

BC fosters an environment where all served can recover. BC currently employs 8 full time staff members who have completed the Certified Peer Specialist (CPS) training program. These Peers are deployed across CBFS teams and ESPs and bring tremendous value through their lived

experience with severe and persistent mental illness. The Peer Specialists work one-on-one with clients, educate other team members, and help promote the organization's philosophy of hope, recovery and resilience. BC also employs Peers who facilitate groups at the Wellness Center.

The first step in V's recruitment screening includes questions that specifically assess a candidate's recovery oriented perspective. If a candidate moves on to the interview phase for a position then V Managers are trained to recruit staff with a strong foundation in PR and recovery practices. The interview process is multifaceted and includes a client interview component. This helps obtain the client's perspective, as well as observe the candidate in a similar environment in which they will be working. V provides clinical placements/internships for students from area schools of social work. It has had a similar experience as BMC as described above.

2.4.2 Integration of Peers and Family Members

2.4.2.1 Commitment to Recovery-Oriented Services: Peers are represented on a number of BMC committees, including the DoP Ambulatory Services Core Managers group, the Peer Navigator Project, and the BEST and Cambridge/Somerville ESP Advisory Committees. BMC invites MBRLC leadership and Peers to participate in key meetings and committees and to have a voice in decision-making and in program design. MBRLC leaders participate in many community, state, and national boards related to mental health and recovery movement programs. Additionally, the SERLC has agreed to work with BMC and its partners in the planning and implementation of ESP services, in the recruitment, hiring and training of Peer Specialists, and in providing trainings for ESP staff.

BC welcomes consumer and parent participation throughout all services. Consumers and parents are active participants in the BC Human Rights Committee, and the Board of Advocates.

V understands the tremendous value people with a lived experience bring to the company. Its current Director of Recovery Services has published articles and book chapters to advance this field. V's two PACT teams employ recovery Specialists. The Cambridge/Somerville RLC employs one person in recovery and the SERLC employs 13. Each of the CBFS assertive action teams has at least one recovery Coordinator, for a total of 20. V has 15 CPS staff employed in various programs. The Director of Recovery holds monthly peer supervision groups regionally for all staff employed in peer positions within the organization. All people in recovery who work at V are encouraged to attend monthly "Lunch and Learns" with the Director of Recovery to learn together and support each other. Peer Workers are encouraged to participate in regional or statewide groups for CPS, PACT Recovery Specialists and other focus groups and obtain CPS training as a key credential for their work.

2.4.2.2 Current and Planned Peer Engagement: Currently, the Peer Director of the MBRLC is a member of the Core Planning group for this ESP proposal, and is integral to the design of a program model that incorporates Peer Workers. For more than a year, Peers from the MBRLC have worked with clients in the BEST CCS and on DMH inpatient units in the Solomon Carter Fuller Mental Health Center, conducting support groups and providing information about recovery and treatment resources. At least annually, members of the RLC do presentations for the BMC DoP Grand Rounds series and for the all staff training sessions for staff of the BEST and Cambridge/Somerville ESPs.

Since the inception of the recovery movement in the state of Massachusetts, it has been BC's practice to hire Peer Specialists in the ESP; and since the 2009 advent of CBHI, Family Partners. Peers and Family Partners act as consultants to the team on recovery based experience and treatment, working with Clinicians in all phases of the evaluation and follow up. Peers act as a

resource in the referral process, maintaining a database of recovery oriented resources in the greater Massachusetts area.

The numerous Peers within V's workforce provide training to their co-Workers on topics related to recovery and resiliency. V has several active Family Councils throughout the CBFS programs. These Councils are in place to advise leadership as to what is going well and what isn't in services. Clients are active participants in the V Human Rights Committees. The role of the Peer Worker in the CCS will be to ensure the environment is one that promotes safety, recovery, and treatment. The CPS staff will also provide a peer-to-peer support and psycho-education about wellness and recovery.

2.4.2.2.1 Hiring and Integration Strategies: An important recruitment strategy BMC, BC and V employ is requesting that Peer leaders in the community identify potential candidates. All post opportunities on web-based sites such as Idealist and Craigslist. Other targeted efforts include postings in the Transformation Center's bi-monthly Recovery Network News (RNN) e-bulletin, Boston Resource Center (BRC) and SERLC websites and emailing opportunities to neighboring RLCs for distribution within their networks. RNN is a significant resource, as many of its e-bulletin subscribers are CPSs. RNN's job posting is regarded as the most comprehensive listing of peer jobs in the Commonwealth. MBRLC leadership is well-connected to other organizations that post job opportunities and have access to potential candidates: NAMI, VA, Depression Bipolar Support Alliance (DBSA)-Boston, Casa Primavera, the Ruby Rogers Center, the Friends of Metro Boston, and its partners by subcontract (V and BC), with DMH Case Managers and on the new MBRLC website job page.

Family Partners and Peers will be active members of the ESP teams. As such, they will attend staff meetings and trainings with their clinical team-member colleagues. They will also attend weekly peer-facilitated support groups for Family Partners and CPS/Peers. Family Partners and Peers will also have regular individual supervision.

BC has hired, trained and retained many CPSs in programs such as CBFS, the Wellness Center, the Peer Education Resource Center and the BEST program. Family Partners have worked as part of MCI since the start of the CBHI. The BC CPSs meet as a group on a weekly basis and provide and receive peer supervision in this and other settings.

V's recruiting staff, accompanied by one of its Peer Workers, visits the GIFT (Gathering and Inspiring Future Talent) Training graduations to discuss opportunities available at the agency. GIFT has become desirable training that young adults seek prior to moving into the CPS training program. Peer Workers will be Mental Health Workers on the CCS. They will attend staff meetings and trainings with their colleagues. They will have individual supervision with the Lead Nurse or CCS Director. They will participate in the regional peer supervision provided by the Director of Recovery and have the option to attend the "Lunch and Learns".

2.4.3 Adherence to Recovery Principles

2.4.3.1 Professional Development Activities and Trainings: Please see Attachment 6.

2.4.3.2 Integration of Recovery Principles into Practice: BMC has involved Peers in various aspects of program planning and delivery since the establishment of the peer-run BRC in September 2005. The commitment BMC made at that time was to integrate the philosophy of recovery, strength-based approaches to treatment, and consumer choice and decision-making into every program within the BMC DoP. We have made much progress in this regard over the years. BMC received the DMH grant to lead both the MBRLC and the SERLC. There are Peers on the ESP Advisory Committee and on the Ambulatory Services Core Managers group. Peers participate in the orientation of ESP staff. When ESP Clinicians and other treaters convene to

develop crisis plans for clients, those clients are strongly encouraged to participate and to lead the development of a plan to guide future care. Peer members of MBRLC who will be integrated into the ESP assist consumers to develop Wellness Recovery Plan (WRAPs).

The treatment approach of BC is based on the belief that all individuals have the potential to grow, acquire skills and develop strategies to better manage everyday life and the effects of a mental health condition. This approach is demonstrated as BC works with individuals to assess their present strengths, preferences, goals and needs and incorporate them into the interventions. When available, natural or generic community supports, such as family or friends, are incorporated into treatment plans. BC embraces the tenants of the SAMHSA consensus statement on recovery.

V has taken significant steps to measure the degree to which its staff act in ways that promote the recovery of people it serves. It developed and instituted a data collection system focused on Quality of Life Outcomes (QOLO) to measure the effectiveness of the rehabilitation strategies and support it provides to clients. One of the measures included in the QOLO data is the Milestones of Recovery (MOR) rating. This scale is completed monthly and measures a person's progress in his/her path to recovery using a 1-8 scale. Effective planning requires true collaboration with the client and targets interventions of the correct type and intensity. The goal is not to plan *for* clients, but to plan *with* clients. All new employees participate in 10 training modules (39 hours), with skill outcomes and learning objectives for all trainees. V has recently completed a two year process of mapping the competencies needed.

2.4.3.3 Anticipated Challenges and Mitigation Strategies: The medical and clinical leadership of BMC Psychiatry have been strong and vocal proponents for strength-based and recovery-oriented treatment for many years. In the spring of 2005, our Medical Director approached MPower and individual Peer leaders to enlist their assistance in establishing a formal presence at BMC. With BEST they have continued to nurture these efforts. The advances we have made over the intervening years make us optimistic that our ongoing challenges will continue to be minimal, as staff response and buy-in to our efforts has been enthusiastic.

BC and V anticipate minimal challenges to recovery-oriented services. The agencies will continue to promote this value through person-centered care planning, the inclusion of Peers and Family Partners in its programming, and ongoing teaching, training, and supervision of staff. BC and V will consider the cultural and linguistic needs of clients, staff, and community partners in the implementation of these practices.

2.5 Culturally Competent Services: BMC, BC, and V individually and collectively have long delivered culturally competent services. These providers recognize both the risk of disparities in access to effective care for racial, ethnic, linguistic and cultural minorities, and the significance of culture to the effective treatment of mental health and substance use conditions.

2.5.1 Population and Related Experience

2.5.1.1 Demographics: Between 40 and 50% of the residents of Fall River identify themselves as being of Portuguese descent. Nearly 20% of all residents in Fall River were born outside the United States. Other cities in this catchment area have an average immigrant population of 8%. 66% of Fall River residents speak English only; residents of other cities in the catchment area average nearly 90% English only. In all cities, about half of all people who do not speak English as a primary language do still speak English "very well".

2.5.1.2 Experience Providing Services to Populations: BMC's BHS reflect the culturally rich ethnic populations it serves. More than half of BMC patients have an annual income at or below $20,420. About 75% of BMC patients come from under-served populations, including low

income families, elders, people with disabilities, minorities and immigrants. A first-of-its-kind program nationwide, the Boston Center for Refugee Health and Human Rights at BMC treats over 400 patients from more than 70 countries each year providing comprehensive health, social and legal services to refugees, asylum seekers and survivors of torture. Thirty one percent of BMC patients do not speak English as their primary language. BMC's medical interpreter staff provides in-person coverage for 24 languages to assist in emergency psychiatric evaluations. Approximately 190 additional languages are available for telephone interpreting. BC has overseen services to cultural and linguistic minorities since the 1990's. BMC will link with its partners, BC and V, to address the ethnic minorities identified in the FR-ESP area.

The demographics of the FR-ESP population are well known to V. The staff has experience working with clients from different cultures and has designed rehab plans to meet specific cultural beliefs and practices, including Western European, Cape Verdean, Sub-Saharan African, and Brazilian newcomers. These practices have included adjusting engagement strategies and developing culturally relevant community supports for clients. V hires staff to reflect the cultural diversity of the communities served and ensures that there is full integration in both direct service and management roles. Staff assist clients in making connections back to resources within their cultural communities, a powerful tool in a person's recovery.

2.5.1.3 Culturally and Linguistically Appropriate Programs and Staff: BMC has no specific culturally- and linguistically-tailored program models that are currently operated, with the exception of Latino team in the child ambulatory services. Though BMC has considered pursuing this approach to treatment services, it was not thought to have been feasible because of the sure number of ethnic minorities seen at BMC and/or its affiliated health centers. Also, BMC believes it crucial to increase the cultural competency of all providers.

V's La Casa Hispania residential program serves people who share similar cultural heritages, most of whom do not speak English. La Casa staff are Spanish-speaking and bicultural. The services are designed and delivered with cultural sensitivity. V runs the CBFS in Lowell, home to the second largest number of newcomer Cambodians in the country (10.37%), and to a large number of those of Hispanic descent (14.01%). As many Cambodian refugees have experienced significant trauma in their homeland, V's trauma-informed approach has enhanced its work with residents who may have relocated experienced trauma in doing so. They have hired Cambodian and Hispanic staff to work with these clients. V provides staff with historical and cultural information (attitude, family influence) and how these impact the client's mental health. V currently serves individuals who are Hispanic, Latino, Haitian, or Asian in many of its sites and employs this approach in each program it operates.

BC has long operated specialty residential and clubhouse programs serving Spanish, Portuguese, Vietnamese, Cantonese, and Mandarin speaking adults. The programs are staffed by employees from the respective cultures who are minimally bilingual. BC also operates two specialty CBFS teams who work with these populations.

2.5.1.4 Efforts to Engage Populations Who Underutilize ESP Services: BMC will use natural community resources to outreach to ethnic and linguistic minorities. This will include outreach to entities such as faith communities, schools, and local newspapers. BMC will also utilize educational opportunities such as health fairs to educate individuals regarding PES and mental health issues and will seek input directly from communities regarding outreach strategies.

2.5.2 Organizational Capacity

2.5.2.1 Capacity to Provide Culturally and Linguistically Competent Services

2.5.2.1.1 Current Composition of Governance and Senior Management: BMC recognizes the importance of diversity at all levels of the institution, including the Board of Directors and the senior leadership responsible for the governance and oversight of this ESP. Twenty five percent of BMC Senior Management Team and the Board of Directors are of cultural/ethnic minority. Ethnic minorities compose approximately 15% of the senior leadership team responsible for the oversight of the ESP program.
2.5.2.1.2 Board of Directors' Initiatives to Strengthen Cultural Diversity: During the past several years, BMC has undertaken several initiatives to increase cultural diversity in its workforce and management team. These are described in Attachment 7.
2.5.2.1.3 Number of Bilingual/Bicultural Staff and Reflection of MassHealth-Enrolled Population: Forty-two percent of the BMC ESP Mobile Teams and CBL staff are bilingual, as are 24% of the Call Center staff and 45% of the clinic staff. Spanish is the most common linguistic capacity reflected in the BMC behavioral health staff. Minorities represent 64.2% of V's staff (Black/African American are 52.8%; Hispanic/Latino are 6.8%; Asian are 1.4%). In addition American Indian/Alaska Native, Hawaiian/Other Pacific Islander and those with two races are represented as well. White/Caucasian represent 35.8% of V's workforce.
2.5.2.1.4 Interpreter Services: BMC recognizes that it is necessary to maintain a stellar interpreter service in order to provide excellent medical care. In addition to providing face-to-face interpreters on-site in 24 spoken languages, American Sign Language (ASL), and Certified Deaf Interpreting, the department utilizes the latest advances in technology such as telephonic and video interpreting, in order to provide around the clock interpreting services to patients in 190 languages. V and BC arrange external consultation to staff; provide ongoing site based training to improve staffs' cultural competence; continuously work to build relationships with community agencies; and use family/social supports with client consent for translation/interpreter services. They are also committed to hiring bilingual/bicultural staff who speak clients' languages.
2.5.2.1.5 Professional Development Activities and Trainings: Please see Attachment 6.
2.5.2.2 Delivering Culturally- and Linguistically-Competent Care: BMC's DoP has a rich and longstanding history of providing care to a diverse patient population. Their approach to diversity and commitment to cultural competency can best be expressed in BMC's diversity statement, "the Medical Center remains committed to creating and sustaining a work place and a hospital where employees, patients, and patients' families are respected and valued not in spite of, but because of the differences in their backgrounds and cultures". Honoring the diversity of communities will promote and ensure mutual respect, collaboration, and productivity necessary to provide the highest quality care. This perspective that has informed BMC's psychiatric services. Please see Attachment 7.

V's staff receive ongoing site based training on cultural competence to ensure sensitivity to the impact of culture on clients' identity, beliefs and experience of their illness. V ensures that staff are sensitive to each client's unique needs and prepared to adapt clinical interventions and treatment based on culture and ethnicity. V recruits a diverse staff, accesses translators when necessary, respects and celebrates cultural differences, and links clients to culturally relevant community supports.

BMC, BC and V anticipate the need to serve clients who are diverse in terms of gender identity and sexual orientation. They orient, train and supervise staff to respect all clients, and to demonstrate sensitivity and acceptance of their sexual orientation and gender identity.

2.5.2.3 Institutional Initiatives to Strengthen Cultural and Linguistic Competency: Efforts in this area are documented in Attachment 7.

2.5.3 Experience Partnering with Minority, Community-Based Organizations: BMC and its DoP have extensive experience in linking with other community-based organizations and in meeting the service needs for refugee/immigrant populations. BEST has as a key element of its design linkages with community based organizations. BMC also has a multi-service Center for Refugees which was founded and organized within the DoP at BMC.

BC and V have partnered with community organizations that teach English as a second language, provide cultural connection and social options for clients, and translation services, including community action committees, public libraries, community colleges, counsels on aging, churches and other faith based organizations, and the Massachusetts Commission for the Deaf and Hard of Hearing.

2.6 Other Special Populations

2.6.1 Elders: In 2010, ESP clinical staff acquired online certification in the assessment of elders from the Boston University Institute of Geriatric Social Work. This was initially sponsored by MBHP and additional training slots were paid for by BMC to solidify core competency of BEST clinical staff. BEST has continued to provide services to elderly clients and agencies serving elders and various other programs, especially when a home-based assessment is the most comfortable and most appropriate for the client.

BC, through Kit Clark Senior Services, has an integrated continuum of services that provide support for about 4,000 elders each year. Services include Adult Day Health, residential support, Meals on Wheels and the Medeiros Center for Change, the first and only shelter for older adults in Boston. Staff conduct the programs in five different languages.

The existing V services and programs have a solid record and strong commitment to providing BHS to individuals in place as they age. As clients grow older, V honors their desire to "age in place" by enhancing services with ongoing access to nursing staff. V staff know how to modify sites, convert their use, and adjust interventions to meet the developmental needs of older clients.

2.6.2 Veterans: The metro Boston area has a dense population of veterans, including homeless and/or disabled veterans and has a significant array of behavioral health, medical, and housing/shelter services for this population. BMC has strengthened its understanding of the needs of this population and the resources available. BMC's role with the MBRLC offers an important resource. BMC psychiatry residents do rotations at both Bedford and Boston VA Medical Centers. Those residents also treat BMC patients through the ESPs and clinics.

From 2003-2011, V ran the Peer Education and Support program for veterans (Vet to Vet). The critical components of the Vet to Vet program are mutual support, promotion of individual responsibility, leadership, self-advocacy, self-determination and participation in the recovery process. V provided this service in 41 sites to approximately 1200 veterans.

Veterans receiving services through the ESP will be referred to housing programs, addiction services, community based treatment and more acute services when presenting with high acuity.

2.6.3 Persons Who are Homeless: In 2015, 30% of BEST encounters were for homeless individuals and/or families, as is typically characteristic of the urban environment. Consequently, the metro Boston area is rich in resources for this population. BEST recently partnered with the Pine Street Inn by deploying an ESP Clinician on a regular walking route with one of the Inn's street outreach Clinicians in order to help address the emergency mental health needs of high risk homeless individuals. This initiative proved successful in terms of reaching out to difficult-to-

engage mentally ill (and typically untreated) individuals; strengthening the assessment capacity of these homeless outreach initiatives; and enhancing the core competency of the ESP vis-à-vis homeless populations.

Both V and BC have more than 30 years of experience engaging homeless adults with serious mental illness and co-occurring addiction in housing and supports through PACT, clubhouses, CBFS, and specialized rehabilitative and employment supports. V's Dudley Inn Safe Haven uses a "Housing First" philosophy to help people who have experienced long-term homelessness to live at the Inn and eventually work toward permanent housing. It offers medical and psychiatric care on site and helps with daily living skills, and housing search services. V's Homeless Outreach Team serves 140 homeless people each year with psychiatric conditions on Cape Cod helping connect people in need with supports. BC has extensive experience serving homeless adults with psychiatric and addiction disorders, operating the Boston Night Center, the Albany Street "wet" shelter comprising 100 beds in Cambridge and other programs.

2.6.4 Persons with Substance Use Conditions: About 35% of BEST encounters involve individuals with substance abuse or dependence disorders. As such, BEST clinical staff have well-honed assessment and intervention skills. Within BEST's partner agencies' cadre of services there is a rich continuum including: outpatient addiction services and dual diagnosis outpatient treatment services, inpatient detoxification, outpatient methadone, Enhanced Addiction Treatment Services (EATS), SOAP, Adolescent SOAP, school-based addiction education and support, and residential treatment. Close collaboration with ESP has enhanced its effectiveness in needs-appropriate linkages and care access for patients. Ongoing trainings on substance abuse assessment, treatment and motivational interviewing have been provided to BEST Clinicians. Several Psychiatrists within BMC's behavioral health clinic are certified to provide Suboxone treatment.

Approximately 10% of individuals presenting at the CCS at Cape Cod are struggling with substance use conditions. BMC will employ a harm reduction approach and access substance treatment programs services as indicated and desired by the stage of readiness of the client

2.6.5 Persons with Co-Occurring Mental Health and Substance Use Conditions: In 2015, 65% of BMC ESP encounters involved persons with co-occurring mental health and substance abuse conditions. ESP Clinicians have a strong orientation toward assessing and understanding the needs for this patient population. Training for this population has been included in program wide and component-specific trainings. Treatment integrates engagement strategies, medication assistance, psychosocial education, supportive counseling, and peer support, available to all clients regardless of "readiness" for abstinence or interest in treatment. V and BC have relevant experience and expertise in the implementing such programs.

2.6.6 Persons who are Deaf and Hard of Hearing: BC utilizes DPH interpreter services for persons who are deaf and hard of hearing. V also provides services to such individuals. It uses interpreters to assist in ensuring culturally competent, person centered services are provided. It has had clients in its CCS, CBFS, outpatient, and DDS services access these supports.

2.6.7 Persons who are Blind, Deaf-Blind, and Visually Impaired: The BMC ESP does not currently have expertise in this area; however, to further develop competencies in serving special populations, it would seek consultation from the Massachusetts Commission for the Blind, including its Deaf/Blind Multi-Handicapped Services. Also, the Director of the peer-run BRC is sight impaired and has provided consultation and training to ESP staff.

2.6.8 Persons who are Department of Mental Health (DMH) Involved: BMC ESP has a very close collaborative relationship with DMH in the metro Boston Area. Communication and

collaboration are enhanced by virtue of BMC Psychiatry and ESP senior administration, the Call Center, CBLs and CCSs being located in two of the state office buildings that house DMH services. ESP provides consultation and MCI to DMH programs and venders throughout the area. Mobile team supervisors and the ESP Clinical Director participate in risk review meetings and crisis planning for DMH-eligible individuals. BEST provides a DMH-specific respite bed on its CCS. BMC's close collaborative relationship with DMH has resulted in smooth and efficient delivery of services to DMH clients and greater satisfaction from DMH and vendor providers. The BMC ESP MCI Director works closely with DMH/DCF Caring Together program.

V's PR Division is dedicated to the recovery of more than 5,000 adults and transitional age youth living with psychiatric disabilities, substance addiction, and/or HIV/AIDs. Much of the service provides to these individuals is funded by DMH. The majority of services are outreach-oriented assertive community treatment serving 2,700 clients via CBFS and PACT services. V provides many other services including CCS, RLC, and Safe Haven, among others.

BC provides many services to people also served by DMH. PACT staff provide needed services in a personalized and integrated way. The PACT model is uniquely responsive in that the team operates seven days a week and is available by telephone twenty-four hours a day. BC's CBFS serves 1,100 adults living in Boston. Additional services offered by BC are the Safety New Outreach Team, the Michael G. Gill Wellness Center, the Gill Clinic, Center House Day Treatment, Transitions of Boston and The Boston TPP.

2.6.9 Youth and Families who are Department of Children and Families (DCF) Involved: BMC ESP has significant involvement in providing crisis services for DCF-involved children and families. In order to ensure effective and efficient coordination of services, the ESP and the four Boston area DCF offices collaborate on a crisis planning initiative (recognized by former DCF Commissioner Angelo McLain as a best practice). Monthly and as-needed meetings facilitate coordinating care and planning for individuals who have been high utilizers of services or identified as high risk. Often, these meetings may take place at the point the client is being discharged home from a hospital. All involved providers, family members, and the child/adolescent are encouraged to participate. The written crisis plan remains in the ESP EMR system, and in the DCF online records system, for easy access when a crisis evolves. Overall, providers and consumers have reported positive satisfaction, and data has indicated a significant drop in re-admission rates. This process has improved lines of communication and collaboration between BMC ESP and DCF area offices. The BMC ESP MCI Director works closely with the DMH/DCF Caring Together program.

V staff work with youth in the Transition to Independence Program (TIP) who are in DCF custody and with adults whose children are in custody of DCF in CBFS. Staff maintain a collaborative relationship with DCF staff, as allowed by the client and/or guardian, often to coordinate care and plan for individuals who have been high utilizers of services or identified as high risk.

2.6.10 Youth and Families who are Department of Youth Services (DYS) and/or Juvenile Court System Involved: BMC ESP sees a significant number of youth in the DYS system. Within the current catchment area there are two DYS locked facilities, which utilize the ESP on a frequent basis. Meetings are held on a regular basis between the ESP UCC Directors and the DYS Clinical Coordinator and other family members and providers to develop crisis plans often centered on hospital diversion. BC has worked with DYS in developing risk management and screening protocols for high risk clients. Overall the relationship with DYS has been very strong and has resulted in effective service delivery and excellent client care. V staff have similar

experience with DYS as described above in 2.6.9 with DCF. BC BEST and DYS have a close collaborative partnership. After two completed suicides in DYS facilities, BEST was invited to help create screening protocols for detained and committed youth in DYS. To date this partnership is one of the closest collaborations BEST has with community providers.

2.6.11 Youth who are on the Autism Spectrum: BMC's Autism Resource Program assists and empowers those affected by autism spectrum disorders through direct patient support, provider education and community based trainings in a culturally competent manner by offering high quality and comprehensive care to all. The program also provides psychosocial support and resource assistance to families in the program. The in-clinic and online comprehensive Resource Libraries compile various resources to educate, inform, and support providers and families in navigating an autism diagnosis, and subsequent issues or concerns that may arise.

2.6.12 Persons receiving services from the Department of Developmental Disabilities (DDS): The BMC ESP's distinct, dedicated 24/7 crisis intervention team for recipients of DDS services receives partial funding from DDS. Individuals with developmental disabilities generally benefit from a specialized intervention. Inpatient admissions can often be diverted by linking the natural support system with increased formal supports, or by troubleshooting and addressing environmental issues that may be causing behavioral outbursts or other high risk behavior.

V offers a comprehensive array of services for individuals with intellectual and developmental disabilities, autism, visual and hearing impairments, and physical disabilities. It partners with individuals, their families, their employers, and their communities to help people receive the services they need to achieve their goals and attain independence. V supports nearly 1,000 individuals in 80 service settings in Massachusetts.

Both BC and V offer extensive residential and day services for adults with development and intellectual disabilities, including specialized group homes (intensive medical, behavioral, addiction, and forensic), day habilitation, and employment and community based day services. BC also offers family support, supported housing and individual support services for youth and adults with development and intellectual disabilities. Both V and BC have board certified behavior analysts (BCBAs) that direct their behavioral and clinical services.

2.7 Intersystem Planning and Affiliation: The target consumer populations have complex social, medical and behavioral health needs which are typically met through a diverse, and sometimes not well integrated, array of services in the community. BMC and its partners have been talking with a variety of community agencies within the FR-ESP area. In these discussions, we have shared our philosophy and experience in delivering ESP services in metro Boston, and have asked them to inform us about the attributes of the population they serve, their service needs, and any gaps identified in the current ESP delivery model. This information has helped inform the program design for this proposal. We have also asked representatives from these agencies to continue to work with us, should we be successful in our bid; this includes being represented on our ESP Advisory Committee. Below we describe our approach to engaging these diverse parties in planning efforts and developing working affiliations.

2.7.1 Experience Convening Collaborative Structure: BMC has successfully developed Advisory Committees for its ESPs, to review trends, service gaps, and barriers, and to identify potential remedies for identified issues. The committees also provide direct feedback to ESP leadership on performance. BMC ESPs also convened area CBFS vendors and other stakeholders in a Safety Forum to create and communicate inter-agency protocols across 24/7/365 systems. BMC ESP representatives regularly participate in newly forming and existing community forums where system strengths, barriers, trends, and opportunities are identified and discussed.

2.7.2 Processes and Structures to Collaborate with Other Stakeholders: If successful in this bid, BMC will replicate its effective model of intersystem planning and collaboration in BEST for the past 12 years. That is, the ESP Clinical Director, MCI Manager, and the Managers of the CBL/Mobile teams will meet regularly with DMH (including participation in risk management meetings), DCF (including regular development of crisis plans for shared clients), staff and leaders of DYS facilities, DDS, medical Directors of the EDs in our service areas, school personnel, police officials, courts, and shelter system representatives. In these meetings, we invite feedback on services provided and will engage with our community partners.

BMC will convene an Advisory Committee, as BEST has been doing, comprised of representatives of key stakeholders, including agencies in the service area, consumers, the Parent/Professional Advocacy League, the Massachusetts Chapter of NAMI, homeless services, substances abuse services, DCF, DYS, DMH, public schools, area police departments, and ESP leadership staff. The committee will provide the essential stakeholder perspectives and expertise necessary for continued ESP quality and service improvement. We would also be involved in existing area forums and lead developing forums as issues present.

2.8 Initial and Ongoing Training, Monitoring, and Evaluating Staff and ESP Program: Program goals, mission and philosophy are clearly described to candidates during recruitment for each ESP component. We emphasize the investment and belief in the power of community-based evaluation and the use of diversionary services to best serve clients and stakeholders. Hiring Managers seek applicants with strong community experience and commitment to these shared values. All new ESP hires are oriented to all ESP components, the content of which is reinforced through required monthly all-ESP staff meetings devoted to training or continuing education. For several years, consumers have trained ESP staff (e.g. "In Our Own Voice" and "Principles of Recovery" presentations) and staff have worked with consumers and Peers from the BMC-led MBRLC and SERLC. ESP clinical staff members receive regular supervision during which each Clinician's cases and records are reviewed. This vehicle serves both as a teaching opportunity (e.g. around assessment and clinical decision-making) and as a way to review the staff member's knowledge of community resources and diversionary services for ESP patients. The ESP electronic record has embedded reports that allow the Clinician and supervisor to review data elements. Call abandonment rates and other information is available in the electronic call log for the Call Center. This information is available both by team and by Clinician, provides timely feedback, and can facilitate practice improvements.

Emergent needs for additional policies, systems and programs are discussed at the weekly Clinical Leadership Committee meeting. Any changes to the goals, philosophy, and business approach must be discussed and approved by the committee to ensure consistency of practice across all components of the ESP. The committee devotes time to discussing strategies to improve diversion rates from ED and inpatient hospitalization. Similar conversations occur at staff meetings. The Clinical Leadership/QM Committee reviews ESP performance in relation to key performance specifications required by payers ongoing. Data collection and report mechanisms built into the EMR system facilitate BMC's review of current and factual information. This year, BMC began an annual review of the ESP and staff members based on the BMC Universal Performance Standards, including putting the patient first, customer service, teamwork, communication, and professionalism.

3. ESP Service Components

3.1 Emergency Services Program (ESP)

3.1.1 ESP Program Model: Prior to seeking the BEST contract for Boston in 2003, BMC surveyed key consumer, advocacy, provider and public safety stakeholders to request their input in the proposed program design. The ongoing Advisory Committee comprised of stakeholders meets bi-monthly to provide continuous feedback on BEST performance and to generate solutions to questions and challenges that arise. If this bid is successful, we plan to replicate this process of engaging with stakeholders to carry our ESP model, described in more detail below, into the Fall River area.

Our program is based on the principles of: 1) upstream timely access and response; 2) seamless integration of ESP components; 3) community knowledge and linkages; 4) strengths-based and person-centered interventions; 5) services congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served; 6) recovery, empowerment and peer support; and 7) staff competencies in community-based crisis management and resolution. These principles are embedded within all elements of our program and their linkages.

The strength of BMC BEST is the partnerships we have developed with our sub-contractors and leverage to provide seamless services. Strong oversight by BMC as the lead agency emphasizes cohesion, communication, and uniform practices. Services are delivered via specialized components that work as a team to manage crisis encounters. These components for FR-ESP will be the centralized 1-800 BMC Call Center number staffed by master's level Clinicians; BMC Psychiatry clinical leadership providing 24/7/365 supervision, consultation and administration; the BC mobile team that will dispatch from CBLs; and a seven-bed CCS operated by V, co-located with BC at the primary CBL site.

Our model uses a "discrete level of care" for individuals in behavioral crisis that is more robust than a simple screening and triage program. BMC BEST provides a highly integrated system of acute behavioral services with clear linkages to other elements of the system of care. Our program cares for individuals for discrete periods of time until the acute behavioral crisis ends or until the individual can be safely connected to other levels of care, often within the ESP itself and such as follow-up visits, urgent psychopharmacology and crisis stabilization at our voluntary unit. When medically necessary, persons in crisis are connected to the appropriate level of care within the broader community continuum, as well as social services and natural supports.

Our experiences over the past 12.5 years in caring for individuals until they are bridged to community supports helped establish our family and youth-focused seven-day crisis stabilization option using MCI. It enables our ESP to respond to the evolving nature of the community-based behavioral health system for people of all ages.

3.1.2 Changing Perceptions: We will build upon our success in the current Boston ESP (BEST) to promote the principle of ESP as a discrete level of care in the FR area. Already, we have met with representatives of major community-based providers, peer and essential services working with children, adolescents and adults in the catchment area. They have made initial commitments to collaborate on a comprehensive crisis response system as reflected in the Letters of Support attachment. Building a community continuum of crisis response helps all parties understand the individual's needs, preferences and history; intervene earlier in the crisis; and resolve the crisis in the least restrictive manner thereby enhancing the individual's self-efficacy and community tenure.

3.1.3 Realizing the Vision and Managing ESP: In order to realize our vision for a robust FR-ESP and manage this critical service effectively, we will employ the following strategies:

- Use of regular communication regarding policies and practice across all components of the ESP; meetings, supervision, daily phone contact, trainings, utilization review, case conferencing;
- Documented policies and procedures as reviewed and endorsed by all component leadership; and
- Emphasis on hand-off protocols. See Attachment 8 for BC Report as an example of existing protocols for shift change and coordination between teams. See Attachment 9 for de-identified BC Case Tracking sample. The case tracking document is accessible by all BC staff to ensure coordinated assignment and follow up.

3.1.4 Fluidity among Service Components: Our cross-functional team will support each other to cover upward fluctuations in volume. The Call Center serves as the central information and support component, aware of case flow and assisting mobile teams in juggling their responsibilities. Supervisors with administrative duties will support cases as required by demand.

Similarly, mobile team Clinicians, when available, will provide additional clinical services to CCS as well as support to psychopharmacologists providing urgent bridge medication appointments.

The EMR will track response times to help identify outliers and barriers that need attention. The Call Center will triage every request for service, and in those instances of lower acuity, will work with the caller to arrive at a mutually agreed upon opportunity for assessment and early intervention.

3.1.5 800# and Triage Function: Our toll-free number serves callers 24-hours a day, seven days a week. By using the 1-800-981-HELP Call Center, a caller is provided with support, information, referral or evaluation. Calls made to the Call Center are screened for intake, evaluation, and assessment. The Call Center may dispatch a crisis intervention mobile team to the site of the crisis, direct the individual to an UCC/CBL, or, when unavoidable due to safety or medical acuity, direct the party to an ED.

The Call Center serves as the nerve center of the ESP. The Call Center maintains live management of cases being seen throughout the ESP system and works to triage new cases according to availability of staff. In addition, the Call Center provides support, information and referral for the many callers who are not requesting evaluations. The Call Center works closely with the Metro Boston/SERLC Peer Support Line which also serves the FR-ESP area. The Call Center links callers who need to talk to the Peer Support Line. In times of high demand, Call Center Clinicians support the mobile teams by completing the final assessment stages (e.g., bed searches, linkages to community-based programs, and shift change transfers).

The Call Center is staffed by master's level Clinicians to offer exceptional clinical expertise and crisis management. Staffing is at the highest level during peak hours of calls, 9 a.m. to 11 p.m., with two Clinicians answering calls from 11 p.m. to 7 a.m. The first day-shift Clinician takes over at 7 a.m. and is quickly supported by the next, who arrives at 8 a.m. Additional staff is staggered throughout the day, with peak hours served by a minimum of six Clinicians on weekdays and four on weekends.

3.1.6 Covering the Entire Catchment Geography: We anticipate establishing one CBL in the catchment area. However, opportunities exist to use the continuums of care of our partners V and BC, as well as other community-based services as described throughout this application, to establish "outposts" for mobile team utilization. Clinicians will also be dispatched from home.

3.1.6.1 One-Hour Response Time: In the Fall River area, variables concerning geography and effects of longer driving distances will be considered during response time analyses. Using ESP and other community partners' locations as outposts will be further developed. Clinicians will not always report to an office but rather will be dispatched directly from home. Having a web-based EMR and other technology, such as cell phones and iPads, offer great flexibility for locating staff throughout the catchment area.

3.1.7 Rationale for Variances in Service Model: BMC's current ESPs operate an 800# Call Center that is situated with a CBL of the Boston ESP. In serving the FR area, we propose to expand the Call Center's responsibilities to the new area. Though not co-located with the CBL under this proposal, use of the existing Call Center represents an efficiency gained through economies of scale. Given that the entire ESP is connected by an EMR that operates in real time, and with other technological options for communication, we believe the skill and experience of Call Center staff outweighs benefits gained from co-location. The call volume, triaging and dispatching duties of the Call Center, as well as the additional responsibilities involved in backing up mobile teams (e.g., coordinating bed searches and accessing consultation resources), can all be integrated for multiple catchment areas. The ESP Cost Report details additional new call center staff.

3.1.8 Location of Services

3.1.8.1 Locations and Hours of Operation: While the ESP will have a primary CBL, we will also try to partner with community agencies to establish "outposts" in the catchment area where mobile Clinicians can be staged in order to reduce response time.

Service Component	**Address Where Service will be Delivered/ Dispatched from**	**Days/Hours of Operation**		**Other Services at this Location**
		Of the Service Component	**Of the Physical Site**	
ESP Senior Management Functions	85 E. Newton St. Boston, MA 02118	24/7/365	8A-5P, M-F	800# and Triage; existing BEST CBL/CCS
ESP Director; MCI Manager	TBD	24/7/365	8A-5P, M-F	TBD
800# and Triage	85 E. Newton St. Boston, MA 02118	24/7/365	24/7/365	ESP Senior Management; existing BEST CBL/CCS
CBL	TBD	24/7/365	24/7/365	Mobile teams; CCS
MCI	TBD	24/7/365	24/7/365	Adult mobile team; CCS; CBL
Adult MCI	TBD	24/7/365	24/7/365	Youth mobile team; CCS; CBL
Adult CCS	TBD	24/7/365	24/7/365	Mobile Teams; CBL

RAP (Runaway Assistance Program)	TBD	4:30P-8A, 24 hours/day weekends and holidays	NA	

3.1.8.2 Location and/or Substantive Physical Plants Changes: The current Fall River ESP is located in DMH space that will no longer be available. In the time span between the potential award of the contract and the date of operation of the ESP program, our partner V's facility and real estate staff would make the location of a site for this program a priority. V has a proven track record of identifying and locating program sites under pressure with limited time available. Furthermore, V has a strong presence in the Southeastern MA area and is familiar with local commercial realtors.

3.1.9 ESP Management

3.1.9.1 Qualifications/Resumes

3.1.9.1.1 ESP Director (not yet hired): Per requirements of the Massachusetts Privatization Law, recruitment for a qualified ESP Director will include consideration of individuals working with the current ESP and terminated as a result of DMH no longer providing the ESP services. Full qualifications of the ESP Director are described in Attachment 10.

3.1.9.1.2 Quality/Risk Management Director (not yet hired): Per requirements of the Massachusetts Privatization Law, recruitment for a qualified Quality/Risk Management Director will include consideration of individuals working with the current ESP and terminated as a result of DMH no longer providing the ESP services. Full qualifications of the Quality/Risk Management Director are described in Attachment 11.

3.1.9.1.3 Medical Director: See Attachment 12.

3.1.9.2 Organization Chart: See Attachment 13.

3.1.10 Psychiatry Staffing: BMC BEST currently meets the psychiatry standards of the Request for Response (RFR) performance specifications and will use this experience of providing 24/7/365 services to staff the FR-ESP. BMC will provide all needed psychiatry services, including both direct and on-call services. BMC has adult and child-qualified Practitioners as well as Psychiatrists and Clinical Nurse Specialists on-staff through its DoP and will hire as needed to provide expanded ESP services. The CCS unit will have daily face-to-face rounding with either a Clinical Nurse Practitioner or Psychiatrist. A Psychiatrist will be on-call 24/7 for consultation with CCS and mobile teams, both adult and child. Clinical Nurse Specialists will provide urgent psychopharmacology appointments for ESP referral.

BMC possesses within its ranks, a broad range of discrete capabilities to treat children, adults, elders and their families. BMC DoP is highly regarded for its staff competencies to treat trauma, neurological conditions, other co-occurring behavioral and medical conditions, and acute care situations.

3.1.11 Safety: The proposed FR-ESP will employ several strategies to assure safety, including:

- The Call Center assesses risk by report of referral source, person(s) on-site with individual to be evaluated, and by reference to past electronic records;
- Use of two-member teams when needed clinically or due to question of safety;
- Request for police to meet at community site, if situation merits;
- No fewer than two staff will be onsite at the CBL at any given time; and

- Adherence to current BEST Policy, *Response to Requests for Community-based Evaluation in Situations Felt to be Dangerous,* Attachment 14, with said policy to be amended to reflect catchment area.

3.2 Community-Based Location: BMC and its partners are well known for their practice of providing highly accessible CBLs for even the most acute and secure services to children, adults, elders and their families. We recognize that both unique characteristics of our client populations and best treatment practices demand accessible, community-based care settings.

3.2.1 Community-Based Locations

3.2.1.1 General Description: The current ESP site serving the Fall River Area is located in a state-owned building and will not be available for use upon the award of this contract. Given some uncertainty regarding the exact start date of the contract for these services it is not feasible to establish site control at present. Any ESP site should include the following qualities and features: a welcoming appearance and atmosphere, parking, signage, waiting and treatment areas and staff work space. As of this writing there are at least fifteen commercial sites available for lease in the Fall River central business district that would provide a setting for developing a high quality site in a convenient location. The South Main Street area will be one possibility considered. Upon contract award an intensive search to locate a suitable process would be undertaken in collaboration with at least one local realtor.

3.2.1.2 Rationale for Location: This site is located in the most populous city in the catchment area. Fall River is not only easily accessible by I-195 and multiple state highways; it is also a hub for the region's transit authority.

3.2.1.3 Rationale for Perception of Community-Based Location: A site near the South Main Street area would be located near numerous commercial establishments, churches, and parks.

3.2.1.4 Proximity and Access to Public Transportation: Proposal for a yet unidentified site: This area is served by the Southeastern Regional Transit Authority. Several bus lines connect Freetown, Somerset, Swansea and Westport to the South Main Street area of Fall River.

3.2.1.5 Physical and Interpersonal Climate: The CBL will be painted in soothing colors and decorated to create a warm, calming environment. Care will be taken to decorate and purchase furniture which provides a comfortable environment, as opposed to an institutional feel. Food and beverages will be available at all times. Space will be dedicated for a play area for children, which will include toys and books. Creating a positive interpersonal climate begins with our staff. Every employee of the ESP and CCS will be encouraged to focus on the following principles in their work with people in crisis: putting consumers first, trust, teamwork, open communication, integrity, professionalism, flexibility, adaptability, and accountability. Peer Specialists will be especially well-placed to offer support regarding the process of assessment and what to expect as matters unfold.

3.2.1.6 Differentiating and Communicating Crisis Behavioral Health Services: Access to the site will be controlled in a humanized way (e.g. minimal to no use of intercoms or door buzzers to allow entry), individuals entering the site will be greeted in a reception area where they will be welcomed and the purpose of their visit, if not already known, will be determined. What each person entering the site can expect during their time there will be explained to them, indicating in a compassionate way that they are there for a particular reason, and should expect an organized response to their presence. Individuals who present for the apparent purpose of social support will be directed to other resources, e.g. RLC, Peer Support Line, parent support line, or Clubhouse program.

3.2.2 Community-Based Locations Supporting Goals of ESP

3.2.2.1 Community-Based Location's Support of ED Diversion: One of primary goals of our current ESPs is to divert behavioral health utilization from the hospital EDs. As part of this effort, it is critical to provide a CBL that is well-publicized, accessible, and welcoming. The fact that the site is not located in a hospital setting is known to have a positive effect on diverting activity away from EDs. It has been demonstrated that community-based dispositions occur at a significantly higher rate when the ESP is community--not hospital--based. Transportation services will be arranged for in advance to deal with times when the volume of individuals presenting for ESP services is so great that services at the ESP site will be the preferred option. This strategy is another way to divert from EDs, even when the ESP is operating at high capacity. The location creates opportunity to calmly focus on the issues at hand without the pressures of a high intensity, potentially trauma-infused medical emergency setting.

A challenge in the **Fall River** area will be introducing clients to a new site, given that the DMH site presently used for CBL and CCS will not be available. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients who present at Corrigan Mental Health Center in crisis are triaged with the ESP and not referred to an ED.

3.2.3 Staffing

3.2.3.1 Flexible Use of Staff: All staff within the ESP will be cross-trained to serve multiple functions within the entire ESP and flex between components as part of the daily expectation. Co-location of the CCS with the CBL and the use of fluidly trained staff will enhance the ability to respond to varying levels of demand and share resources. For example, the CPS may run a group at the CCS, then accompany a mobile Clinician for an evaluation at a client's home.

3.2.3.2 Certified Peer Specialists: In many instances the most important intervention is the one in which the client is seeking help for the very first time. The clinical transaction that takes place can determine whether that individual continues on his or her path to recovery or walks out feeling less than hopeful. Our Peer Specialists work side by side with Clinicians to create a welcoming and hopeful intervention. Our Peers are essential team members and help Clinicians visualize and engender hope on behalf of the clients and families we serve. Peers function flexibly on the service facilitating interventions at the CBL and in the community alongside mobile crisis Clinicians. For example, a Peer followed up with a client who had been made frequent 911 calls to communicate her distress to police. Once it became clear that the client was not in need of clinical resources, the Peer and patient came up with a list of resources that the client felt would be helpful to her when she was distressed. After this intervention, her 911 calls stopped altogether.

3.3 Adult Mobile Crisis Intervention

3.3.1 Adult Mobile Crisis Intervention Services: BEST is governed by the philosophy that most behavioral health crises can be effectively addressed in the community. There is an ingrained culture among the current emergency services staff that unless there is an emergent medical or safety concern, evaluations should occur in the client's natural setting. BEST recognizes that providing emergency services on a mobile basis requires a special set of skills on the part of the Clinician, accessibility and support from the supervisory level and an understanding within the community as to the benefits of providing this service outside of an ED. We will expand this existing philosophy and culture throughout the new catchment area.

Mobile Clinicians will be based at the CBL between the hours of 7a.m. and 11p.m. Between the hours of 11p.m. and 7a.m., two Clinicians will be available to respond on an on-call basis.

Calls for services will arrive at the Call Center, staffed 24/7/365 by Masters-level Clinicians trained in crisis intervention and management. Triage Clinicians will respond to the needs of the caller and, following an assessment, make a decision whether to dispatch a Mobile Clinician. The triage Clinician will document in the web-based system the person's demographic information, location in the community and description of the presenting problem. This information will be instantly accessible to the Mobile Clinician. Mobile Clinicians will then drive to the location of the individual and provide crisis intervention, evaluation and stabilization services. Depending on the location and severity of the presentation, Mobile Clinicians will team up with a Master's Level Intern, Bachelors Level Staff or CPS. In some circumstances they may request the support of the local police department.

Mobile Clinicians will be equipped with cell phones and laptop computers with secure/encrypted wireless internet access. Clinicians will have the capacity to document their evaluations on the web-based system from any location in the community. If the Mobile Clinician needs to immediately dispatch from one location to another, their evaluation will be instantly accessible to other members of the team, who can proceed with a bed search or assist with any follow up. All consultations are either provided by a licensed clinical mental health professional or are reviewed by a licensed clinical mental health professional. If Clinicians are considering utilizing a locked inpatient psychiatric hospital, an on call Psychiatrist is contacted to review the intervention to be certain that patient meets criteria for Section 12. Philosophically, the team leadership and Clinicians in the field are committed to providing ready access to acute care services and the default intervention is one which happens in the community where the collateral providers deliver services and can contribute to the intervention in real time.

The team is also committed to meeting patients where they are at emotionally; when a crisis occurs, patients, providers and families can be stressed and the crisis intervention offers the patient a safe space to talk through their experience and put a plan in place for crisis management. The team is committed to affect tolerance and provides high level risk management during the course of intervention. The team does not believe in hospitalization if it serves to make the provider or worried family member feel better. It must truly be the intervention of last resort. The BC mobile crisis team is comprised of staff who have language capacity including: Spanish, Haitian-Creole, Russian, French, ASL, and Cantonese. Once a case is triaged the Clinical Manager can assign a Clinician to the intervention who would provide the best clinical fit for the intervention. Clinicians on the team have trauma-informed training and are trained around risk mitigation and use of natural resources.

3.3.2 Staff and/or Certified Peer Specialists: BMC plans to provide adult mobile services to the entire catchment area served under this proposal. Some mobile visits may require the assistance of a second staff person for several purposes: added support in situations where safety considerations could make a lone Clinician uneasy about providing outreach; assistance with cultural and language issues for which the second staff member has expertise; help with making phone calls to supports or coordinating access to diversionary treatment programs; and periods when the team is busy and a second person's assistance would facilitate moving the intervention forward in a timely way.

Similarly, the CPS and bachelor-level staff/master's level interns, perhaps credentialed with CPS, will be important team members in some mobiles to community sites, just as CPS staff will be integral players at the CBL. Peer Specialists offer individuals in crisis and the clinical staff working with them another perspective on the process and potential ways to help stabilize the situation. Their training in the rehabilitation and recovery model will help cultivate a strengths

approach during the intervention. BMC BEST has successfully integrated Peers into its current ESP and will seek to replicate this process in the subject catchment area. Additionally, the MBRLC is active in ongoing development of the CPS role for BEST, and its expertise includes being able to introduce the development of WRAPs with individuals seen by the crisis team. We will encourage our CPS staff to request permission of persons seen in crisis to have follow-up for the purpose of creating a WRAP to help guide any future crisis interventions.

Our current ESPs have a robust system of training for master's-level students. For example, BEST BC CBL/mobile team had from September 2014 to August 31, 2015, a total of 12 interns: one for 12 months, seven for nine months and four for four months. Their weekly internship consisted of 16-20 hours, and interns trained on week day, evening and weekend shifts. These placements translated into four Full Time Employees (FTEs). Students are invested in their training, and because of longstanding relationships we have with various field placement personnel, we request applicants who have experience in the field predating their master's programs or who can demonstrate the level of professionalism and poise required to do the challenging fieldwork. Prior to placement, students are interviewed by either the program Director, Assistant Program Director or Team leader. They receive scheduled, weekly supervision from licensed supervisors. BC Mobile Team interns attend the agency's two-day orientation, the two-day PREVENT Training, and, if not currently certified, First Aid/CPR. They also attend a four-hour overall BEST orientation. In essence these social work and mental health counselor trainees carry out many tasks that meet and exceed the criteria of bachelor-level staffing. The program has welcomed students who are in recovery. We anticipate that the FR-ESP will likewise develop a strong training program, bringing additional resources to the team and staff, likely in the amount of two FTEs.

3.4 Adult Community Crisis Stabilization (CCS)

3.4.1 Program Description: V will provide a staff-secure, safe, and structured crisis stabilization and treatment service in a CBL that serves as a medically necessary, less restrictive and voluntary alternative to inpatient psychiatric hospitalization. Admissions and discharges will occur 24/7/365. The CCS will be primarily used as a diversion from inpatient services. However, the service may be used as a transition from inpatient services when there is sufficient service capacity, and admission criteria are met. The CCS will serve adults ages 18 and older, including youth ages 18-21 under the Children's Behavioral Health Initiative (CBHI). The CCS will serve up to seven adults at one time. This program will be co-located with the Emergency Services Program (ESP) and will work collaboratively with the ESP to develop short-term, effective interventions to help each client resume their everyday life and facilitate short length of stays. The CCS will provide nursing supports on each shift and have access to psychiatric support 24/7. While clients are in the CCS, further evaluations will be made by nursing and medical staff (MD/CNS/NP), including medication evaluation. Appropriate follow-up services will be initiated so that once the crisis for the client has passed; s/he will progress successfully to a less intensive level of care. A crisis/safety plan will then be created. Peer Specialist staff will help each client to create a WRAP when needed; these plans will be given to the client to take with him/her at discharge. Also, WRAPs will be entered into the client's electronic record so that they are available to ESP providers in future. The final essential function of the CCS team is to stabilize the client and coordinate follow-up services with Primary Providers, Therapists, day program staff and Psychiatrists in his/her community.

The primary service objectives of the CCS multi-disciplinary team are to:

- Restore functioning;

- Strengthen the resources and capacities of the client, family, and other natural supports;
- Support a timely return to a less restrictive community setting;
- Develop and/or strengthen the client's individualized risk reduction/safety plan; and
- Link the client to ongoing, medically necessary treatment and support services.

The flow of the service is as follows:

1. The CCS operates 24/7/365 for adults ages 18 and older. The CCS provides staff secure, safe and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive and voluntary placement.
2. The CCS services are short-term, providing 24-hour observation and supervision and daily re-evaluation and assessment of readiness for discharge.
3. The CCS provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services.
4. CCS services include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; mobilization of and coordination with family and other natural supports, community providers and resources; psycho-education, including information about recovery, rehabilitation, crisis self-management and how to access recovery and rehabilitation services available in the individual's specific community.
5. Individuals admitted to the CCS will have a community based disposition plan upon admission to the CCS.
6. The CCS will work closely with the ESP in order to enhance service continuity and fluidity between services.
7. The CCS will have a home-like, calm and comfortable environment that is conducive to recovery.

The CCS will be staffed by a lead RN, LPNs, Mental Health Workers and Peer Specialists. One RN will be designated as the lead/charge Nurse for the unit. S/he will receive support from the Nurse Manager of the BMC ESP. Medical coverage will be provided by a Clinical Nurse Specialist/Nurse Practitioner with MD backup, and treatment rounds that include the CNS/NP will occur daily. The CNS/NP/MD will meet with each client daily. Clients served by the CCS may have a range of psychiatric and behavioral symptoms yet cannot exhibit psychotic symptoms to the point of being disorganized or acutely/actively suicidal. Clients may have chronic medical conditions, but must be medically stable.

3.4.2 Physical Plant: The CCS will be configured in double bedrooms, with some limited single bedroom capacity. There will be kitchen space for the maintenance and preparation of snack food and meals. The space will include a lounge/living area and office space to provide for individual meetings with clients and to provide workspace for staff. A secure medication room will also be included.

3.4.2.1 Space: The site for the Fall River CCS is currently co-located with the ESP team in a state operated facility. It is our understanding that we will not be able to use this space in any capacity during the transition of the program. Therefore, we will seek a space that is located in a commercially zoned area in Fall River, MA. It will be in an area that will tolerate high traffic and night use of the space, and has outdoor space and a large parking area. The ESP will be able to operate in this building with sufficient resources for staff, meetings, and waiting areas.

3.4.2.2 Strategies to Create Environment and Culture: Creating a positive interpersonal climate begins with our staff. Every employee of the ESP and CCS will be encouraged to focus on the

following principles in their work with people in crisis: putting clients first, trust, teamwork, open communication, integrity, professionalism, flexibility, adaptability and accountability. Peer Specialists will be especially well-placed to offer support regarding the process of assessment and what to expect as matters unfold. As mentioned in the RFR itself, we have also found that small measures of comfort, such as snacks, refreshments, periodicals, music and other modest amenities are important. We will use our experience in creating a cheerful, efficient and useful space in operating current CCS programs to continue the operation of this CCS.

3.4.3 Co-Location of the Adult CCS with the ESP Community-Based Location: The UCC for walk-ins and the office space that serves as home to the Mobile Team will be located within the same building as the CCS. Thus, following the crisis evaluation, the staff may easily escort the client to the CCS for admission if indicated. The co-location will be in place at the point of implementation of the contract.

3.4.3.1 Co-Located CCS and ESP Space: Given the resources of BMC, BC and V, we anticipate the ability to identify and secure the appropriate space for the CCS and ESP program by the start date of the contract. The space will be used for the UCC, walk-ins and an office space that serves as home to the Mobile Team. Likewise, CCS staff will work closely with the ESP team for seamless communication about clients and program components. Our goals will be to provide adequate space for efficacy and comfort, and to allow all parties to work closely together collaboratively.

3.4.3.2 Co-Location Status at Implementation of ESP: Co-location shall be in place upon implementation of the ESP contract.

3.4.3.3 Not Co-Located at Implementation of ESP: Not applicable.

3.4.4 Recommendations and Rationale for Reallocation of CCS Capacity: We plan to negotiate with MBHP to increase the capacity from six to seven beds due to an experience of an ability to manage a capacity of that level, as well as an assessment of need of the area based on past experience of the sub-contractor V. We will manage utilization by tracking and regularly reviewing average daily census and length of stay, as we currently do in all BMC ESP programs. Given the staffing intensity of RN and MD resources to the unit, we are able to serve higher acuity patients, including those in need of detox, who are psychotic, have suicidal ideation and who have more active medical co-morbidities.

3.4.5 Communication Plan between Adult CCS and Other ESP Service Components: The weekly Clinical Leadership meetings described elsewhere in this proposal will include Managers of the UCC/Mobile Team and CCS, so that they are at the table with the Medical Director, the ESP Clinical Director, the QM/RM Director and other clients of Senior Leadership. The Managers will have a voice in overall decision-making for the ESP. Also, these Managers will meet weekly in Operations meetings for case review and utilization management review. There will be all-ESP staff meetings monthly where procedural issues will be discussed and trainings will be presented. On a daily basis, the ESP Clinical Director and UCC/CCS Managers will collaborate around staffing needs and volume flow so that resources may be shared and assigned accordingly.

3.4.6 Strategies to Shift Culture: We will draw on our experience in the existing BMC ESP programs and meet with potential referrers and agencies within the ESP area to educate them about the capabilities of the CCS. As they are able, we will encourage community providers to visit the CCS to observe the program design and services offered. We have found this to be helpful in our other ESP programs in order to create a level of confidence in the CCS's ability to

manage clients who a referral source may have previously thought required inpatient hospitalization.

3.5 Mobile Crisis Intervention (MCI)

3.5.1 Statement of Intention: The ESP intends to enter into a subcontract arrangement with another entity that meets the requirements of subcontractors outlined in Section V.C. of this RFR. Enter the name of the agency (additional information will be requested in narrative response section 4.3. below). The competency of the proposed subcontractor agency is demonstrated in the section that follows.

3.5.2 Rationale for 3.3.1 and Subcontractor Qualifications: BMC and BC have demonstrated a strong partnership and mutual commitment to the provision of quality MCI services as evidenced by the ongoing delivery of said services for the BEST. Since 2003, BMC and BC have collaborated to provide urgent, mobile and community-based responses to youth and their families experiencing behavioral health crisis. With the initiation of CBHI services in June 2009, those responses expanded to emphasize the Wraparound principles which inform the philosophy behind MCI services, and to include Family Partners in order to provide a bi-disciplinary team which is maximally responsive to family voice and choice. BC has also shown both flexibility and creativity in order to meet the rigorous standards of MCI, most notably with the creation of a Child Focused Team (CFT) within the larger mobile team, whose primary responsibility is to ensure that every family served has access to seven days of ongoing stabilization activities as needed.

3.5.3 Readiness to Provide Mobile Crisis Intervention

3.5.3.1 Behavioral Health Services to Children and Adolescents: As outlined above, BMC and BC have a demonstrated ability to provide behavioral health assessment and resolution focused interventions to youth and their families as the MCI provider for the Boston area since the outset of CBHI in 2009. During the previous fiscal year, the BC BEST team served 2,234 youth. These youth were each provided with an average of more than three days of ongoing stabilization activities by the MCI team, with up to 110 families receiving ongoing support and resolution focused care for up to seven days during the course of one month. BMC additionally oversees the provision of MCI services for the remaining communities in Suffolk County under the BEST contract, as well as the cities of Cambridge and Somerville for the Cambridge/Somerville Emergency Services Program—a combined 5,451 youth served in FY15.

BMC is also home to a robust outpatient Child and Adolescent Psychiatry clinic, serving over 4,500 youth annually under guiding principles which include care that is family-focused, culturally competent and prevention oriented. In operation since 1956, the ethnically-diverse, multidisciplinary team of child and adolescent Psychiatrists, child Psychologists and child-trained Social Workers provides specialized services including comprehensive assessment, advanced psychopharmacology, trauma-focused therapy, social-emotional skills-training groups, psychoeducational testing and parenting skills training.

Also since 1956, BMC Child and Adolescent Psychiatry has provided consultative services to primary care Practitioners and hospitalists in the BMC Department of Pediatrics around the psychiatric assessment and management of physically ill or injured children. Through educational symposia, collaborative rounds and informal consultation, consulting child Psychiatrists also play a major role in increasing the capacity of primary care Practitioners to deliver basic mental health services in the context of pediatric practices.

Since 1997, the BMC South Boston Collaborative Center has provided intensive outpatient substance abuse treatment services to youths in the South Boston community. The Center

provides a broad range of outreach, prevention and treatment services in collaboration with its lengthy roster of community partners. Beginning in 2005, BMC Child and Adolescent Psychiatry also has provided consultation to Clinicians providing mental health services in school-based health clinics in Boston Public Schools high schools, and has placed child and adolescent Psychiatrists and Clinical Nurse Specialists in community health centers linked to BMC, including Whittier Street Health Center, Dorchester House and South Boston Community Health Center.

In addition to providing MCI services through BEST, BC operates three community-based programs which provide a range of BHS and support to youth and their families: The Family Support Center, BC Academy and the Early Intervention Program. The Family Support Center provides both information and support to approximately 300 families per year who identify themselves as struggling with mental or behavioral health concerns. The culturally diverse staff at this center offer seven different service components for family members to participate in depending on their needs: information/referrals, trainings, support groups, parent networking, community connections/resources, and service navigation. Imbedded within the Family Support Center, and serving an additional 100 families per year, is the PSP. The PSP is staffed by parents and caretakers with lived experience navigating the behavioral health system on behalf of their loved ones, and in addition to the services offered at the Family Support Center, the PSP provides both online and in person parent groups, one-on-one support from a parent partner and educational advocacy.

BC Academy is a therapeutic school setting which served 27 students during the last academic year. BC Academy provides a high-intensity program that addresses the individual academic, social, behavioral and career development needs of its students. The entire school serves as a therapeutic milieu where students focus on individual emotional development, while at the same time completing a comprehensive academic program. Students are offered a comprehensive academic program, career development and transition services and individual and group therapy.

The BC Early Intervention (EI) program serves children under three years of age who are developmentally delayed, have a known disabling condition or are at risk of developmental delays due to biological or environmental factors. The program's goal is to promote the physical, mental and emotional development of eligible children. Services are provided in the children's homes, in the community and at the program site on Victory Road. Last year the Early Intervention program served 1,113 youth and their families across these settings. BC's EI program has been providing such services to children and their families for the past twenty years. Depending on the needs of the individual child, interventions can include:

- Multidisciplinary developmental assessments;
- In-home developmental play stimulation;
- Toddler developmental play groups, including transportation, if needed;
- Parent education and support groups;
- Individual or family therapy;
- Speech therapy, occupational therapy and physical therapy; and
- Service coordination and advocacy.

3.5.3.2 Knowledge, Commitment, and Experience Implementing Services to Children, Adolescents, and Families Consistent with Systems of Care and Wraparound Principles: As a current provider of MCI services to the Boston area, BC has a thorough knowledge of Wraparound principles, and over six years of experience providing services utilizing the System

of Care philosophy as a guiding principle. BC staff, as well as clinical leadership from BMC, have attended trainings on the implementation of MCI beginning with the initial roll out of CHBI services in 2009, where an emphasis on care that is child-focused and family-driven was made from the outset. Since that time staff have continued to improve their fidelity to the Wraparound model with additional trainings on the Crisis Continuum, Resolution-Focused Interventions, and the best practice utilization of the seven-day period following an initial evaluation. BCMCI providers have also received Technical Assistance trainings from consultant Kappy Madenwald on multiple occasions, most recently in June of this year. In practice, BC provides a bi-disciplinary response including a child-trained Clinician and Family Partner to youth and families in a variety of community-based settings including homes, schools, provider offices, community centers and an UCC which is available to families 24 hours a day. BC employs an ethnically and linguistically diverse staff, and interventions are delivered in a manner consistent with a family's individual cultural considerations. Under the supervision of the MCI Program Director at BMC, continual efforts to improve the quality of the services delivered are made, including the use of daily record reviews and in-the-moment consultation to staff providing MCI services.

3.5.3.3 Competence Working in Partnership with Youth, Parents, and Other Caregivers of Youth with Mental Health Needs: Recognizing the unique knowledge and contributions that Family Partners have made since being introduced to the provision of emergency services, the BCMCI team has shown a commitment to youth and families by continuing to increase the staffing level of this valuable position. Both BC mobile staff and the clinical leadership at BMC have observed the positive shift toward family-focused practice and the increase in shared decision making that occur when a caregiver's voice and choice are amplified by the MCI Family Partner. Family Partners have also proven to be an effective bridge to reaching families that might otherwise be reluctant to engage in MCI services, but who could benefit from additional support to maintain their youth in the community. For example, there have been numerous occasions where the BC MCI team has been contacted by a community based provider working with a family; the provider believes the family might benefit from MCI intervention, but they have been reluctant to engage due to lack of knowledge about the service, misperceptions about what it will entail, or both. In those circumstances a BC Family Partner has offered to meet with the family before an MCI intervention is ever requested in order to answer any questions a parent or caregiver may have, and to talk to them about the family-directed nature of MCI practice. When these meetings have occurred families have almost unanimously given the feedback that they would feel more comfortable in calling the MCI team than they had previously, and very frequently the outcome is a request for MCI intervention from the family themselves.

3.5.3.4 Policies, Procedures, and/or Clinical Protocols for Provision of Behavioral Health Services to Youth and Families: Please see Attachment 15: Child Focused Team Description which describes the composition and responsibilities of the CFT, a subset of the larger MCI team that carries out stabilization activities on days 2-7 of the MCI intervention; Attachment 16: Youth Consultation Protocol which outlines the consultation requirements for all evaluations of youth ages 0-20; Attachment 17: Youth Boarding Protocol which describes the clinical interventions and consultation requirements for youth boarding in the community for a 24 hour level of care; Attachment 18: MCI Hand off Protocol which outlines the procedure for the BMC ED to request ongoing clinical intervention for a youth being discharged from the ED, to be completed by the MCI team.

3.5.3.5 Outcomes Data, Quality Improvement Processes, Satisfaction Survey Instruments and Results Focused on Services for Youth and Families:

BCMCI Quality Indicators for FY 15

- Community Based Interventions Youth Ages 0-20 - 61.82%;
- Disposition-Inpatient Youth Ages 0-20 - 22.34%;
- Response Time in Minutes Youth Ages 0-20 - 35min; and
- Response Time % Within 60 minutes Youth Ages 0-20 - 82.53%.

Quality Indictors of MCI Service Tracked by BMC

- Documentation of best effort to reach parent/guardian prior to evaluation;
- Children/adolescents who are boarding evaluated every 24 hours after initial evaluation; and
- Increased use of youth boarding at home (vs in EDs) while awaiting CBAT placements, when deemed safe and with caregiver agreement.

As part of ongoing efforts to improve the quality of MCI services delivered to youth and families, the BMC MCI Program Director conducts daily reviews Monday-Friday of documented MCI service delivery by the BC mobile team within the preceding 24 hours. Feedback is given verbally and/or via e-mail to the BC MCI Team leader or CFT designee. Areas of review include:

- Quality and completeness of clinical information documented;
- Evidence of parent/guardian engagement and family-driven resolution; and
- Clear resolution focused goals for ongoing MCI involvement, if agreed upon by the family.

3.5.3.6 Training, Licensing, Certification, Accreditation, and/or Other Documented Verification of Expertise and Experience in Providing Behavioral Health Services to Children, Adolescents, and Their Families:

Child/Adolescent In-Service Trainings

- July 2015: *Community Practice Competencies: Higher Level Skills of a BEST Professional*, BEST Clinical Leadership staff
- December 2014: *Peer-Driven Recovery and Resources*, MBRLC, various staff
- March 2014: *The Art of Triage: A humanistic approach to case presentations for the Emergency Services Professional,* Hisla Bates, MD, Associate Medical Director, Massachusetts Behavioral Health Partnership
- January 2014: *Overview of Psychotropic Medications,* Catalina Melo, MD, Associate Director, BMC PES
- December 2013: *Separating the "T" from LGBT: Working with Transgender and Gender Non-Conforming Clients,* Chris Miller, BSW, MBA
- September 2013: *MCI in Action,* Tasha Kornell, LMHC, Youth MCI Program Director, BEST/Cambridge Somerville Emergency Services Program

Child/Adolescent External Trainings

- May and June 2015: *MCI Technical Assistance Training*, Kappy Madenwald, LISW-S, Madenwald Consulting
- April 2015: *Advancing MCI Practice*, Kappy Madenwald, LISW-S, Madenwald Consulting
- April 2012: *MCI Model Enhancement Regional Forum*, MBHP staff
- January 2012: *Statewide CBHI Family Partner Forum: The Voice of Family Partners*, MBHP staff

3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention:

BMC	BC
On-call Psychiatrist	MCI Team Leader
Director of Quality/Risk Management and Training	Child-trained mobile Clinicians
Clinical Director	CFT Clinician
Assistant Clinical Director/MCI Program Director	Family Partner
	Child and Adolescent Trained Nurse Practitioner

3.5.3.7.1 Résumés: Current Staff Member(s) in Director-Level Positions and Above with Five Plus Years of Experience: Please see Attachment 19.

3.5.3.7.2 Job Descriptions Mobile Crisis Intervention Team: Please see Attachment 20.

3.5.3.8 Experience Integrating Youth and Family Voice in Organization Governance: Individuals with lived experience including CPSs and Family Partners assist both BMC and BC in integrating youth and family voices into our organizational governance. Membership at a weekly Operations Meeting, which brings together leadership from the various ESP components working under BMC, includes a CPS. Peer Specialists and Family Partners also serve a unique and valuable role in the training of new staff and Masters level internship students working for the BC mobile team. Ongoing efforts to highlight family and youth voice will also be made, including extending additional invitations to parents as well as transitional age youth to participate in formal Advisory Committee meetings.

3.5.3.9 Relationships with Child- and Family-Focused Community Resources in Service: As a provider of MCI services since the launch of CBHI in 2009, BMC—in collaboration with BC—has worked to build relationships with partners from across the System of Care in each community we serve, believing that these relationships are an essential component of improving access to high quality services and supports for youth and families. The foundation of these community relationships is to create opportunities to meet with consumers, schools, behavioral health providers and state agencies alike to discuss the individualized needs of each group. Leadership staff from BMC, as well as the MCI Team Leader from BC, participate regularly in multiple interagency forums where child and adolescent resources are the focus, most notably five monthly System of Care meetings that cover the various communities which comprise Boston. These Systems of Care (SOC) meetings are attended by staff from the host CSA as well as providers of other CBHI services, state agency staff from DCF, DMH, and DCF, staff from social service programs working directly with the community, and parents and caregivers of youth. The MCI leadership personnel from both agencies have also gained experience partnering with state agencies through a combination of regularly scheduled meetings, providing MCI related trainings to state staff, mutual participation on community advisory boards and crisis planning meetings to address the needs of specific individuals. One example of these partnerships is the School Based Mental Health Providers Collaborative, attended monthly by the MCI Program Director from BMC as well as the Assistant Director of Behavioral Health for the Boston Public Schools, the Director of Child and Adolescent Services for Metro Boston DMH, leadership staff from DCF and supervisory and Director-level staff from multiple community-based mental health agencies providing services to youth within the Boston Public School system. In addition to creating a document outlining the standards of care for mental health provision in schools, this group has also worked to remedy service gaps for students in need of

behavioral health treatment, as well as facilitating an annual day-long training for school-based mental health staff.

Relating specifically to agencies serving the Fall River area, BMC and BC have an established working relationship with South Bay Mental Health, which provides Early Intervention and outpatient BHS to that area as well as both clinic and home-based therapy in the Boston area. BC MCI staff have made South Bay a frequent partner when referring for community-based services as agreed upon by the family served, with consistently positive feedback from parents and caregivers. BC staff have also attended trainings on special education provided by South Bay, and the MCI Program Director from BMC works regularly with various clinical leadership personnel from South Bay at both the School Based Mental Health Collaborative as well as System of Care meetings.

BMC and BC staff also work very frequently with all aspects of the Arbour Health System, which serves the Fall River area with its in-home therapy and therapeutic mentoring services. BC mobile staff make numerous referrals per year to the Arbour system for youth and families requesting outpatient counseling and psychiatry care, as well as IHT and TM services. BC staff also access the Arbour system's inpatient psychiatric units for children and adolescents requiring that level of care for stabilization before returning to the community.

3.5.3.10 Membership in Child Advocacy and/or Child-Focused Trade Organizations: BMC, BC and V staff are members of the PPAL.

3.5.4 Mobile Crisis Intervention

3.5.4.1 Mobile Crisis Intervention Service and Bi-Disciplinary Intervention: Since 2009, BMC has been committed to the delivery of MCI services utilizing the Ten Principles of the Wrap-Around Process as a guiding philosophy. Throughout an intervention, family voice and choice play a central role in the provision of services, including the need for a culturally competent approach which addresses a family's preferences for setting, language, communication method and inclusion of natural supports. We prioritize providing MCI services in the least-restrictive community setting and on collaborating closely with the family's providers and supports of choice. Requests for MCI intervention will be received at a 24-hour 800# Call Center which will coordinate a response with the UCC located in the caller's community. As often as possible, a bi-disciplinary team including a youth-trained Clinician and Family Partner will be dispatched from the UCC to respond to the requested location, promoting the use of community-based settings whenever possible. The MCI team will gather information from the youth, parents and/or guardians and other collaterals as permitted by the guardians—including both formal providers and natural supports—to gain an understanding of the present crisis and the family's preferences for resolution. During the course of the intervention, the Family Partner will act with particular emphasis on supporting the parents or guardians in their experience of the crisis, as well as the MCI intervention itself, taking care to answer questions about the process and amplify the family's voice and choice. In consultation with appropriate team supervisors, a consensus agreement will be reached with the family regarding next steps to resolve the crisis, including referral to a range of formal and informal supports inclusive of 24hr inpatient care if indicated.

3.5.4.2 Managing Staff Resources to Meet Service Fluctuations in Intensity and Duration: In order to provide maximum flexibility, BMC plans to hire master's level Clinicians for the entire ESP who meets the MCI competency standards or who will acquire competency via ongoing training in the areas of expertise highlighted by the RFR (e.g., comprehension of grief and trauma in adolescents and children, risk assessment, and management skills in working with children, adolescents, and families). We will also seek to staff with primarily full-time

employees, as opposed to part-time, to allow for fullest development of the program and to provide for consistently high quality interventions.

The ESP will use Family Partners and/or other youth-trained paraprofessionals to deliver MCI services in conjunction with Clinicians, and to help coordinate care with natural supports and community-based providers. These staff will interface with families during initial evaluations, and will also be available for ongoing stabilization activities for up to seven days following the initial encounter depending on the volume and intensity of services needed by youth and families in the community.

3.5.4.3 Continued Intervention to Assure Coordination of Care Stabilization and Follow-Up Services: In order to meet the needs of youth and families for up to seven days of crisis stabilization support following an MCI encounter, BMC has developed a bi-disciplinary team of youth-trained Clinicians and Family Partners within the larger group of ESP Clinicians referred to as the CFT. The primary responsibility of CFT staff is to interface with youth and families subsequent to the initial encounter with MCI to develop an individualized and resolution-focused plan to determine which continued interventions will occur, if any. Each family that indicates a desire for continued intervention is assigned a CFT Clinician, Family Partner or both depending on their needs, who will remain the primary contact person throughout the course of the stabilization activities in order to maximize effective communication with the family. CFT staff will work with the youth, their caregivers and other system providers to ensure that the family's goals within the resolution of the crisis are met. During periods of high intensity and duration of MCI stabilization activities, CFT Clinicians and Family Partners maintain a primary focus on working with families for up to seven days following their initial encounter with MCI; when demand for these activities is lower, CFT Clinicians will become more available to conduct first-day evaluations and interventions with youth and families. CFT Clinicians will also become available to conduct initial adult face to face evaluations as needed.

3.5.5 Linkages with Other CBHI Services: BMC has a strong history of partnering with CBHI providers in its provision of MCI services, both during the course of urgent requests for evaluation, as well as building relationships with providers that encourage prevention and early intervention with families served. Attendance and active participation at the System of Care committee facilitated by the area CSA is an important building block for these relationships. It allows the MCI team to develop a strong alliance not just with Intensive Care Coordinator (ICC) and Family Partner providers, but also with other partners who attend the SOC with the intention of improving the health and well-being of the families that make up the community. BMC has also made it a practice to reach out to providers of child BHS including IHT, TM and outpatient counseling, and to offer trainings to the staff of those services in collaborating with MCI to ensure the best care for their clients. With permission from parents or guardians, attendance at CPT meetings or other crisis planning meetings held by providers can also be a means to create positive relationships with both staff and families served, and can aid in the creation of a plan which emphasizes early intervention and least restrictive care.

3.6 Runaway Assistance Program (RAP): As a partner in the RAP, the FR-ESP will make available 24-hour access to designated UCCs to allow police drop offs of runaway youth outside juvenile court hours "Non-Court Hours" being defined as hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically M-F, 4:30 p.m.-8:30 a.m. weekends and holidays. The goal of this program is to provide a temporary and safe place for youth to stay on a voluntary basis, until said youth is transferred to an Alternative Lock-Up Program (ALP) or other appropriate level of service. For

the Fall River area of service, the designated non-secure ALP is Community Care Services at 508-226-6031. The Manager is Tasha Ferguson, LMHC, Assistant Clinical Director and MCI Director.

We will employ the BEST RAP protocol which follows:

After determining that a parent/guardian cannot be located to take custody of the youth in question, police officers will initiate this process by contacting 211 and speaking with the "RAP Specialist," who will then do the following:

- Arrange a 4-way conference call between the requesting police officer/dispatcher, ESP Call Center, and a representative from the non-secure ALP;
- Provide the police with the name and address of the closest UCC;
- Request that a representative from the ALP proceed to the UCC where the youth will be dropped off in order to take custody and transfer the youth to the ALP; and
- Relay any known information about the youth to both the on-call RAP Clinician and the ALP, including name, DOB, last known residence, guardian's contact information, etc.

ESP responsibilities after notification by 211 of a RAP request:

Call Center

- Determine if mobile team staff is present on site at requested UCC—if present, notify that a RAP drop off will occur;
- If mobile team staff is not present, notify CCS staff at the appropriate site that a drop off will occur;
- Contact the on-call RAP Clinician to respond to the UCC; and
- Create a triage with any available information.

CCS

- Greet the police officer and youth upon arrival, and supervise the youth until the on-call RAP Clinician arrives. Of note, the youth is not permitted to be on the CCS unit at any time.

On-Call RAP Clinician

- Respond immediately to the UCC after notification from the Call Center;
- Conduct a brief evaluation of the youth and note any behavioral health or safety concerns to be relayed to the ALP staff upon arrival;
- If the youth is determined to require an acute psychiatric admission (i.e. inpatient or CBAT) attempt to facilitate admission, including contacting DCF hotline as needed if a parent/guardian is unable to be located;
- If not in need of an acute admission, continue supervising youth until pick up by ALP staff, or until the youth is transferred to another appropriate setting, i.e. guardian/DCF custody; and
- Complete documentation of assessment.

Youth will remain at the UCC on a voluntary basis until transfer to the ALP/other appropriate setting. If a youth leaves the UCC after drop off by police has occurred, the following steps will been taken if there is reason to believe the youth met Section 12 criteria during the brief assessment: contact the Psychiatrist On-call to complete Section 12 consultation process as usual. If the youth does not meet the criteria, the referring police department will be notified for the UCC if different from the referring department, the RAP Specialist will be notified at 211, and the ALP Program will be notified at 877-457-3210. Finally, emails with any details regarding the circumstances of the youth's departure will be sent to Tasha.Ferguson@bmc.org and an Incident Report will be submitted to MBHP on the next business day.

For on-call support contact Tasha Ferguson at 603-498-3093.

3.6.1. Experience Collaborating with Local Police Departments, Court Clinics and DCF Relative to Youth: BMC and BC have worked closely with the police departments serving our area—both at an administrative level and with individual area stations—to form mutually beneficial relationships that serve to increase access to appropriate supportive services for youth and families. Most notably, BMC employs two full-time Clinicians who co-respond with police officers in Boston to provide on-scene assessment and intervention for youth and families with behavioral health concerns that come to police attention. The goal of these interventions is to divert individuals from legal involvement when connection with mental health services is the more appropriate response. In collaboration with BC, the BMC co-responding Clinicians can also directly facilitate connection to the MCI team for more intensive stabilization activities by transporting the youth and family to the BC UCC, or by requesting an MCI response to the family's home to continue the intervention in that setting. BMC has also provided informational trainings on MCI services to school police officers, as well as collaborating with multiple different police departments including the Massachusetts State Police to provide a RAP response as requested.

BMC also employs 2.5 full time equivalent Clinicians who work with individuals facing legal charges as members of the Criminal Justice Diversion team. This team works within three Mental Health Specialty Court sessions in the Boston area providing assessment, connection to services and case management support to transitional age youth and adults referred by the court due to ongoing behavioral health needs.

Both BMC and BC collaborate regularly with the DCF around youth and families in the areas we serve. Most frequently this comes in the form of requests for MCI intervention with youth engaged in DCF services—this includes youth residing at home with family, in foster care, at Stabilization, Assessment, and Rapid Reintegration (STARR) programs and at Caring Together residential or group home programs funded jointly by DCF and DMH. In addition to these urgent responses, BC MCI staff participate in DCF crisis planning meetings for youth in the community, as well as in ongoing care planning for youth in DCF custody who are boarding for psychiatric placement with the goal of stabilizing the youth who can then be maintained in the least restrictive setting. BMC leadership staff have also provided informational sessions and training for DCF staff regarding MCI services, and participate in a number of interagency forums with DCF supervisory staff including community System of Care meetings.

4. ADDITIONAL RESPONSE REQUIREMENTS

4.1 Hospitals as Bidders

4.1.1 Why BMC is in a Strong Position to Achieve Goals of the Procurement: BMC's commitment to community-based programs and accomplished leadership have demonstrated success with programs such as BEST, CS-ESP, MBRLC, and SERLC. BMC is a founder and current partner of Boston HealthNet, a vertically integrated network comprised of 14 community health centers, BMC, and Boston University School of Medicine, and which serves Boston's underserved, diverse neighborhoods. BMC is the lead partner of BEST, partnering with two premier community-based behavioral health service providers in Greater Boston, North Suffolk Mental Health Association and BC. BMC is also the lead partner of CS-ESP, partnering with North Suffolk Mental Health Association and Cambridge Health Alliance. BMC has leveraged the knowledge and capability of the community-based providers in combination with its organizational leadership in administration, finance and medical/clinical services to create and implement a community-based ESP model that benefits adults and families in Boston. BMC has also led the development and implementation of successful ED diversion strategies. BMC's proposed Fall River ESP in partnership with BC and V—experienced and knowledgeable community-based ESP providers—will similarly establish a robust community-based ESP in the Fall River area.

In the Southeast Area, BMC developed and has overseen the SERLC programs in conjunction with two capable community-based service providers, Brockton Area Multi-Services Incorporated (BAMSI) and Vinfen. As the lead agency for this important DMH-funded, peer-led recovery service, BMC has helped establish recovery service sites across the Southeast area. The Fall River RCC, is located at 66 Troy Street and is open four days a week. These programs will partner with the Fall River ESP to support persons in crisis.

4.2 Bidders Submitting Responses for Multiple Catchment Areas

4.2.1 Vision, Organization, Implementation and Staffing Plan: Strong partnerships with providers experienced in delivering community-based BHS for youth and adults and with deep community roots, trust, and knowledge are paramount to the delivery of high quality crisis services. BMC therefore proposes to partner with providers that possess these qualities and will provide them with a proven infrastructure necessary to support ESPs, including clinical and medical oversight, QM, financial management, an electronic web-based medical record system, and information technology support. Existing infrastructures such as on-call psychiatry, QM systems, a call center, etc. would support well-staffed community-based urgent care and CCS sites along with enhanced mobile capacity in the Fall River area. Strong collaborations with key stakeholders in the Southeast Area is critical to the efficacy of Southeast Area ESPs. BMC, BC and V have well-established working relationships with many Southeast Area community-based providers and other stakeholders including, BAMSI, Child and Family Services, Growthways, Inc., DMH Southeast Area Office, Justice Resource Institute (JRI), NAMI MA, Arbour Counseling, Fellowship Health Resources, Seven Hills, Child and Family Services, Solid Ground Psychotherapy, Steppingstone, Bay Coast Behavioral, Fall River Psychological Associates and Riverwood Mental Health Associates. BMC also has a strong, effective working relationship with the DDS Regional Director, Rick O'Meara as well as the Area Director, Buddy Baker-Smith, and Site Director, Daniel Fisher of the DMH.

4.2.2 Strengths Realized by Serving Multiple Catchment Areas: We will realize economies of scale in more costly aspects of providing emergency services such as medical and clinical

leadership, on-call systems, call center functions, information technology support, and QM. Economies of scale allow the allocation of more resources to clinical services and staffing thereby meeting the ESP service needs of more individuals and families in the community. The new Fall River ESP will also benefit from BEST's and Cambridge Somerville ESP's intellectual capital, established recovery-oriented culture, community-based support, leadership and peer-inclusive infrastructure, expertise, and lessons learned. Additionally, existing and proposed partners from all four catchment areas will work collaboratively to support each other across catchment areas in times of high demand. Serving multiple areas across the Southeast also provides the opportunity to standardize communication, data collection, policy, procedure and practice which will enhance access and continuity of care for consumers across the Southeast Area. For example, utilization of a web-based EMR on a southeast area-wide basis allows access to client information even if a client is seeking crisis services in other than their own community.

4.3 Subcontracts

4.3.1 ESP

4.3.1.1 Subcontract Names and Rationale for Partnership: BMC plans to subcontract with two organizations in providing ESP services to the Fall River ESP communities.

BC was selected to be a subcontractor because it: 1) is a premier provider of community-based mental health and rehabilitation services for seriously mentally ill adults and children, those with intellectual and developmental disabilities, and persons with substance abuse problems in the Southeast, South Shore and Metro Boston areas; 2) has significant knowledge and expertise in the provision of ESP services as a BEST partner since 2004; 3) has a high degree of expertise in information technology and EMRs; and 4) has a proven track record of valuing consumer leadership and choice, peer support, and family-driven and youth-guided care.

V was selected to be a subcontractor because it: 1) is a premier provider of community-based mental health and rehabilitation services for seriously mentally ill adults, those with intellectual and developmental disabilities, and persons with brain injuries in the Southeast and Metro Boston areas; 2) has a proven track record of valuing consumer leadership and choice, peer support, and family-drive, youth-guided care as demonstrated while a BMC Psychiatry partner in the MBRLC since 2008 and in the Southeast Recover Learning Community since 2012; and 3) has expertise in the provision of ESP CCS services, as evidenced by currently operating the Cape and the Islands DMH ESP CCS in Hyannis and as a BEST CCS provider in the past.

4.3.1.2 ESP Service Components to Be Subcontracted with Each Agency: **BC,** in conjunction with BMC; will provide the Fall River ESP MCI, adult mobile, and CBL services. In addition, BC will develop, implement and maintain/improve the information technology programs to support the Fall River ESP.

V, in conjunction with BMC, will provide the CCS services for the Fall River ESP.

4.3.1.3 Service Components and/or Populations Covered by Each Subcontractor: BC and V will provide their respective service components for the entire catchment area and population.

4.3.2 Management and Accountability of Subcontracted Providers: BMC has a successful track record in the development, implementation and oversight of the BEST program, the Boston ESP program which has three key partners: North Suffolk Mental Health Association, BC, and Massachusetts General Hospital Acute Psychiatry Services. A management structure similar to that of BEST, including Senior Leadership, Clinical Leadership, and Operations and Advisory Committees, will be developed to provide internal and external oversight and monitoring of service delivery, including administrative, financial, clinical, and quality. The Senior Leadership, comprised of the administrative and clinical leaders of the BMC DoP, will be fully accountable

for the Fall River ESP and meet on a weekly basis to monitor the subcontracted services and will regularly participate in the other key committees as well.

4.3.3 How BMC Will Directly Provide the Majority of ESP Services: BMC, as the Fall River ESP contracted ESP provider, will provide a majority of the ESP services: 1) in conjunction with BC staff, will provide the Fall River ESP CBL, MCI, and adult mobile services; 2) Call Center/Triage 24/7/365 staff and functions; 3) all on-call child and adult psychiatry back-up services, telephone and face-to-face, and all direct psychiatry services for the CBL/CCS services; 4) complete financial oversight and claims processing services; 5) the majority of key leadership positions directly involved in the day-to-day operations, including Fall River ESP Director, MCI Program Manager, Medical Director, and QM Director; and 6) the support, expertise and guidance of the BMC Psychiatry ESP Senior Leadership Team.

Attachments

Narrative Response Attachments

ATTACHMENT 1: CONTINUUM OF CARE

Boston Medical Center

The ***Comprehensive Care Program*** in the Department of Pediatrics integrates primary care with specialty care and social services for children with neurodevelopmental and emotional/behavioral needs related to pre-term birth, congenital syndromes and chronic health conditions, and/or have experienced trauma as a result of abuse/neglect, parental abandonment, domestic violence, and parental substance abuse. Most of the children seen in the CCP have complex overlapping health, development and emotional/behavioral issues. Many low-income parents of special needs children tend to engage haphazardly and episodically with the healthcare system and fail to receive appropriate follow-up care and intervention. These parents often face economic hardships, educational barriers, psychosocial stigma, and social isolation as they try to cope with their children's needs and attempt to maintain stability for their families. The CCP, with its multidisciplinary approach, sees from 4 to 6 patients per hour, considerably less than the 8 patients per hour in a regular pediatric clinic. Additionally, during their primary care visit patients also can see a neurologist, pulmonologist, nutritionist, gastroenterologist, and/or a pediatric endocrinologist. This "one stop shopping" model of care promotes communication between all members of the child's healthcare team.

The ***Child Witness to Violence Project***, a nationally recognized, award-winning counseling, outreach and consultation program that focuses on young children who are exposed to domestic or community violence, providing trauma-focused counseling services to children and telephone consultations and referrals to agencies and individuals throughout Massachusetts, including the Department of Children and Families, the courts, other hospitals, neighborhood health centers, Head Start, and schools. The program provides a flexible combination of services, including resource advocacy to link families to basic services including health care, child care, housing, and after-school programs.

The ***Child Protection Team***, consisting of a pediatrician, nurse practitioner and social worker, files reports of suspected child abuse or neglect. The on-call consultation services are available 24/7 to BMC and Boston HealthNet providers.

The ***Elders Living at Home Program*** (ELAHP) helps older adults locate and maintain a permanent residence and allow them to live as independently as possible. ELAHP provides housing search, stabilization, nutrition, and homelessness prevention services. All of the elderly men and women placed in housing and provided housing stabilization services have remained successfully housed.

The ***Margaret M. Shea RN Adult Day Health Program***, licensed under MDPH, is a holistic medical intervention program that provides services in an ambulatory, home-like setting for adults who do not require 24-hour institutional care, but because of physical and/or mental impairment, are not completely able to live independently. Services include nursing, social services, activities, and transportation.

The ***Center for Infectious Diseases*** (CID) provides comprehensive HIV medical care and support services. Many patients experience mental health and substance abuse comorbidities, and approximately 30% utilize behavioral health services. Of these patients, approximately 58% have mood disorders, 80% are dually-diagnosed with substance abuse disorders, 60% meet the criteria for PTSD, and 24% of these patients have reported a history of intravenous drug use. In the CID one-stop-shop model of care, patients receive behavioral health services in the clinic and are referred to FAST Path (described below) for substance abuse treatment.

Facilitated Access to Substance Abuse Treatment with Prevention and Treatment of HIV (FAST Path) provides substance abuse and HIV risk reduction services within primary care settings at BMC for both HIV-infected patients and HIV-negative patients who engage in HIV risk behaviors. FAST Path targets racial/ethnic minority men and women whose alcohol or drug dependence places them at increased risk of transmitting (HIV-infected) or contracting (HIV-uninfected) HIV.

Project ASSERT, (Alcohol and Substance Abuse Services, Education, and Referral to Treatment), has been an ongoing component of safety net services at BMC's Emergency Department (ED) since 1998. During patients' initial point of service, Health Promotion Advocates offer "in-reach" services by consulting and collaborating with hospital staff to offer ED patients alcohol and drug screening, brief intervention, and referrals to health and social resources, such as substance abuse treatment and primary care services. By incorporating substance abuse services within the healthcare setting, Project ASSERT provides patients with comprehensive care in an emotionally supportive and non-judgmental manner. In December, 2014 Project ASSERT celebrated its 20th anniversary from its start as a demonstration grant with over 80 attendees including hospital staff, patients, community agency representatives, and government officials. To date, the Project ASSERT model has been replicated at hospitals throughout Massachusetts, including Addison Gilbert Hospital, Gloucester, Mercy Medical Hospital, Springfield, St. Anne's Hospital, Fall River, and South Shore Hospital,, Weymouth. In addition, it has been replicated at the MidMichigan Hospital System, Michigan.

The ***Boston Center for Refugee Health and Human Rights (BCRHHR)*** is a collaboration of the clinical and academic departments of BMC and Boston University Schools of Medicine, Public Health, Dentistry and Law; the National Center for PTSD; and Global Lawyers and Physicians. The multidisciplinary program provides comprehensive health care for refugees including primary care, behavioral health services, social services, and medical subspecialty referrals. BCRHHR also provides asylum evaluations, dental care, legal services, and a vocational rehabilitation program for survivors of torture and related trauma. In addition to clinical care, BCRHHR educates and trains agencies and professionals who serve these communities; advocates for the promotion of health and human rights; and conducts research.

Bay Cove Human Services

Bay Cove Human Services (BCHS) offers a comprehensive array of clinical mental health services that respond to the varying levels of consumers' needs including: eight Community Based Flexible Supports (CBFS) teams; one specialized outreach team, a Housing First program

(Home At Last); three Clubhouse programs; a Program for Assertive Community Treatment (PACT); Day Treatment; Tenancy Preservation Project (TPP); two specialized residences providing treatment for 12 men with mental illness and problematic sexual behaviors and a former Quarterway residence; 40 community residences with partial and 24 hour care; a Mental Health Clinic, providing psychopharmacology and therapy; a Department of Mental Health (DMH) transitional shelter, and four Community Crisis Stabilization (CCS) programs. BCHS also provides a full continuum of care for those receiving DD services and Child and Family Services including Early Intervention and a High School. Substance Abuse services include a Methadone Clinic with counseling and a 60 bed Transitional Support Services (TSS) program. Kit Clark Senior Services provides Adult Day Health, a Memory Loss Center, in-home services, and a senior drop in center.

PACT: PACT provides state-of-the-art treatment for individuals with mental illness who are unable to participate in traditional services, often because of severe cognitive challenges, discomfort in social situations, significant addiction to drugs and alcohol, homelessness, and court involvement. The PACT model is one of the most extensively researched options and is commonly regarded as the most "evidence-based" approach for community support of people with severe psychiatric disabilities.

The PACT model is empowering in its implementation because it offers clients only what they need, when they need it, usually at the setting where they live and in a manner that is most acceptable to them. In addition to more conventional mental health treatment, assistance is also provided in areas of housing, careers, meaningful relationships, symptom alleviation, and accessing medical care.

PACT provides its psychiatrist, nurses, therapists, and rehabilitation support staff with a manageable caseload so that they can provide needed services in a personalized and integrated way. The PACT model is uniquely responsive in that the team operates seven days a week and is available by telephone 24 hours a day. The level of contact can vary widely – from a single visit each week to several contacts per day during times of crisis. PACT clients are not required to visit the program offices for services. Instead, staff members often make visits to them at home, at work, in local coffee shops and other familiar community settings. Over 75% of services are provided outside of the office. In practice, this means that PACT may provide services such as daily medication delivery to a homeless client on the street, or regular supportive therapy while grocery shopping.

TPP: TPP assists individuals and families with mental illness, addiction disorders, or developmental disabilities who are at risk for possible eviction. This program prevents homelessness by helping these people stay in their current housing, or by helping them access more appropriate housing that better meets their needs.
TPP services are offered to Boston residents who come to the attention of the Boston Housing Court due to serious lease violations that jeopardize their tenancy. Approximately 200 hundred people comprise a routine "Thursday's docket" at the Boston Housing Court, and approximately 25% of these people are estimated to have significant disabilities that jeopardize their tenancy and put them at imminent risk of homelessness.

Represented in the population that comes to the Housing Court's attention weekly are Boston Housing Authority (BHA) residents, veterans, and female headed families. Participants range in ages from young parents with young children to elders. Income levels served include the very poor, who are eligible for transitional assistance from the state, and the working poor, who have very low paying jobs. Given the impact that permanent disabilities have on earning potential, most clients in this program fall in the very poor category (with annual earnings for a single adult estimated at under $7000 per annum). TPP services can mitigate the tragic consequences of eviction and ensuing homelessness for the majority of these people.

CBFS: CBFS are designed to help people with psychiatric disabilities thrive, and not just survive. The process begins with an appreciation of everyone's unique talents, hopes, and dreams. CBFS provides a comprehensive system of supports based on a close partnership between the person served and members of a flexible support team. These supports are continued throughout each person's recovery journey as they progress from structured and highly supported settings, to more independent and integrated ones.

For many people, the journey begins with housing in group homes and support in structured day programs, and then becomes increasingly less restrictive as the individual moves into independent apartments, attends school, or gets a job. However, each person's journey is different and the partnership with the flexible support team staff member helps tailor and coordinate services according to the individual's own values and aspirations. They receive the supports that best fit their needs and talents so that they can gradually regain control over their lives.

By identifying talents and ability, rather than focusing on disability, the CBFS team is able to support high aspirations. As people develop community connections and reestablish relationships with family and friends, they are able to use this growing "social capital" as a substitute for paid supports. Many are eventually able to graduate from services.

The flexible support team structure provides a variety of skilled resources, including peer specialists, nurses, and licensed mental health and substance abuse clinicians. BC's CBFS team serve 1100 adults living in downtown Boston, South End, Chinatown, South Boston, Dorchester, Roxbury, and Mattapan neighborhoods.

BCHS works in partnership with South End Community Health Center and Paul Sullivan Housing, a division of Pine Street Inn, in providing the following services:

- Nine Flexible Support Teams
  - Five by BCHS serving 506 people
  - Three by South End Community Health Center serving 294 people
  - One by Paul Sullivan Housing / Pine Street Inn serving 83 people
- The Unique Safety Net Outreach Team provides Enhanced Urgent Care to 217 people
- Staffed residences
  - 40 are operated by BCHS serving 430 people.
  - Eight are operated by Paul Sullivan Housing/Pine Street Inn serving 83 people

Safety Net Outreach: Some individuals with psychiatric disabilities do not engage in full CBFS services. These people generally prefer to live independently and to have full control over their daily lives. However, they are occasionally in need of short-term support during those times when they are experiencing acute distress or a crisis that requires staff intervention. Some of these individuals are homeless and also reluctant to engage in services or supports that assist them in securing housing.

BCHS has created a Safety Net that provides an innovative and cost effective method of meeting the critical needs of the approximately 200 people in the inner city area who have psychiatric disabilities but are living adequately on their own, and who are either unwilling to engage in services, or are only willing to utilize supports in an intermittent manner.
The Safety Net team includes a Program Director, a full time Peer Specialist, two Outreach Workers, a full time Employment Specialist and two Licensed Clinicians. This team provides a less intense level of case management to people who either need a lower level of support or who are not willing to engage in a recovery partnership, yet can benefit from a connecting relationship so that they are able to access services immediately in times of necessity.

The Safety Net Team helps people with concrete supports, such as securing benefits, providing representative payee arrangements, exploring and finding work, developing crisis plans, and helping those who are homeless access shelter and food. They work to facilitate connections with treatment, rehabilitative, health, legal, and recovery focused services to meet clients' needs. The Team tracks people with at least a once a month contact (face to face, by telephone, or through collateral contact), and maintains a record of each client's status. Though many clients utilize the team much more frequently, Safety Net Outreach offers support seven days a week so that if a client needs back up on a weekend they can readily access services.

The Michael J. Gill Wellness Center: The Michael J. Gill Wellness Center is born out of the CBFS holistic approach to recovery. It is a sad fact that the individuals served are dying on an average of 25 years earlier than other Americans. The Wellness Center has the vision to create opportunities for individuals to achieve the fullest of health and well-being. Groups are open to explore individual choices for lifestyle modifications in the areas of stress management, smoking cessation, physical activity, and nutrition. A peer-run healthy cooking group leads participants in the planning and cooking of a simple healthy meal. An evidence-based nutrition curriculum from the Center for Psychiatric Rehabilitation at Boston University will be offered twice yearly. Community acupuncture for clients is currently being offered at the Wellness Center to promote stress reduction, mood regulation, smoking cessation, and addiction recovery support. Other offerings include Yoga, Peer Recovery, and Substance Recovery groups. The Gill Wellness Center is currently growing and expecting to offer other services in the near future including Tai Chi, nutrition and diabetes education, and expressive therapies. It is open to clients served in the Fuller / BCHS CBFS Program and clients served throughout BCHS's other Mental Health Services.

Michale J. Gill Mental Health Clinic: BCHS assumed operations of the Michael J. Gill Mental Health Clinic in February of 2009. It serves many individuals in Jamaica Plain, Roslindale, Roxbury, and in the general Metro Boston area. The staff of psychiatrists, clinical nurse

specialists, and therapists provide a full range of diagnostic and behavioral health treatment services to adults (21 +), including psychopharmacological, counseling, and psychotherapy for individuals and groups. The clinic specializes in working with people with severe and persistent mental illness, dual-diagnosis, and other related psychiatric disorders. This behavioral health clinic works in close collaboration with the primary care clinic at Lemuel Shattuck Hospital andthe Goldfarb Ambulatory Care Center, and therefore ensures optimal integrated health care.

BEST: BEST is a 24-hour emergency services program for people requiring acute psychiatric intervention. Under the direction of BMC, BCHS is one of four providers who comprise the BEST service network (along with the BMC, Massachusetts General Hospital and North Suffolk Mental Health Association). BEST responds to well over 1,000 "calls" each month from a service area that spreads across metropolitan Boston, Brookline, Chelsea, Winthrop, and Revere, and includes seven hospitals, schools, detoxification programs, jails, community health centers and residences for people with mental illness. The demand for services has steadily increased, as the number of people seeking mental health services has grown.

Working with family members, human services providers, public safety and emergency personnel, and school administrators, BEST responds directly to the site of a crisis situation. The program goal is to keep people who are experiencing a psychiatric crisis out of the hospital by redirecting their care to community based programs like addiction services or family support services, where a successful outcome is more likely. Although hospitalization may often be viewed as the "gold standard," it is not necessarily the best treatment option. BCHS is a critical partner in the BEST operation as it provides crucial services including the Mobile Crisis Team and Urgent Care Center and a CCS unit.

CCS: The CCS unit is an unlocked crisis unit that helps people in an acute behavioral health crisis to stabilize, strengthen their coping resources and supports, and develop a plan to live a better life. CCS offers rehabilitative and recovery focused services that enable people to get through such crises without needing to rely on more costly and unnecessarily restrictive inpatient psychiatric services. As a critical component of the BEST, CCS is operated by BCHS and BMC and offers state of the art diversionary care and provides:

- Psychiatric evaluation and assessment
- Medical, psychiatric, and addiction treatment (including detoxification)
- Psychopharmacology assessment and treatment
- Peer-to-peer support through the Boston Resource Center
- A safe, structured environment
- Education about behavioral health concerns
- Step-down from inpatient treatment
- Referrals to psychiatric and addiction services outpatient treatment, health, social services, etc.
- Coordination and collaboration with treatment providers

House Day Treatment: This adult psychiatric day treatment program offers a variety of specialized groups in a supportive community. These groups provide structure within which to address each consumer's individual, clinical rehabilitation needs. The program is designed for

consumers who are either transitioning from higher level of care (e.g. inpatient hospitalization) or would benefit from additional support and structure to prevent the need for such a level of care. The program works well for people with a wide range of diagnoses and treatment needs. Each consumer participates in individualized treatment and specialized groups, including groups for:

- Dual Diagnosis
- Dialectical Behavior Therapy (DBT) Skills
- Post-Traumatic Stress Disorder (PTSD) / Trauma Survivor Support
- Independent Living Skills

BCHS Day Treatment operates with the philosophy of achievable mental health recovery and offers groups facilitated by consumers of mental health services. The goal of the program is to help consumers transition to less treatment-intensive settings as they are ready. These include educational/ vocational programs, clubhouses, and volunteer settings. Sample activities include sobriety check-in, mental health recovery, goal planning, yoga, expressive therapies, symptom awareness, fitness, and bereavement counseling.

Clubhouses: Transitions of Boston and Center Club Boston are clubhouses for adults with psychiatric disabilities, dedicated to the principles of self-help, peer support, and empowerment. The Clubs offer a safe and supportive environment in which members of the program can work towards building meaningful lives, connecting to the larger community, assuming valued roles in the communities of their choice, and ultimately living as independently as possible. The services provided by the Clubs are individualized and based on each member's needs, strengths, and choices, which are assessed at the time a person joins the program. Each member participates in individualized goal planning with their key staff member at the Club.

Vinfen

CBFS Programs: Since July 2009, Vinfen (V) has been the largest provider of CBFS services for the DMH in the state of Massachusetts. All of V's CBFS services are standardized and based on the evidenced- based practices of Assertive Community Treatment (ACT) and the Individualized Placement and Support Model of supported employment. V operates 18 Collaborative Action for Recovery (CAR) Teams within eight CBFS contracts with DMH. These DMH Sites are Cape Cod and Islands, Plymouth, Metro Suburban, Mass Mental, Cambridge Somerville, Essex North A, Essex North B, and Lowell. The model provides four interlocking components: Collaborative CAR Team(s), Operations Support (includes housing specialty staff), Congregate Settings, and Organizational Support. The CBFS model is a system in which the CAR team and the congregate sites function as one integrated component.

CCS Program: In March of 2012 V was asked to assume the operation of the Cape and Islands CCS program. This program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community based location that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older; including youth ages 18-21 under the Children's Behavioral Health Initiative (CBHI). This program currently has capacity to serve 10 adults any given time. The 10

beds include six CCS beds and four DMH respite beds. The CCS Program works closely with the DMH ESP to develop short term, effective interventions that will assist the individual client in resuming their everyday life. In addition, the CCS team provides nursing on each shift and has access to psychiatric support through the Cape Cod & Islands Community Mental Health Center 24 hours a day. These medical personnel are primary service providers at this program. One of the major functions of the CCS team is to stabilize the individual client and coordinate follow-up services with Primary Care Providers, therapists, day program staff, and psychiatrists in the community.

Program for Assertive Community Treatment (PACT): Since February 2003, V has operated a PACT Team for 80 clients in DMH's Essex North Site; and since July 2007, a team for 80 clients in the Cape Cod & Islands Site. The staff provide support and services in a collaborative effort with clients in a variety of community settings. The PACT program has recruited and hired qualified staff from diverse backgrounds, produced positive outcomes with clients who have the highest challenges/needs, and successfully operated the programs according to DMH and National ACT Standards cited in *"A Manual for ACT Start-Up" (Allness and Knoedler, 2003).* By establishing a trusting and mutually respectful relationship with clients, PACT staff have engaged clients, many of whom had previously refused services of any kind. PACT staff have also helped clients secure part-time or full-time employment, dramatically reduced their use of psychiatric hospitals and emergency services, helped formerly chronically homeless clients secure and maintain housing for the first time in their lives, and collaborated with clients to establish or re-establish meaningful social supports that bring joy and hope to their lives.

Young Adult Services: An emerging priority population for the DMH is Transition Age Youth (TAY) and young adults. V was awarded a contract to provide an evidence-informed practice to TAY called Transition to Independence Process (TIP) in 2005. TIP, a research supported model of support serving an emerging population of TAY, is a strength-based process of working with young people. V began serving this population in the early 1990's and designed supported housing specifically for these young people to avoid group home placement whenever possible.

Clinical Services: V provides a wide range of clinical services to thousands of DMH clients each year. A full range of outpatient services are offered through People Care Clinic, the licensed outpatient clinic, a not-for-profit subsidiary of V for nearly 26 years. Small and specialized, the People Care Clinic serves clients with complex conditions, including Co-Occurring Disorders (COD), and Borderline Personality Disorder.

Psychosocial Rehabilitation: More than 1575 DMH clients a year attend V's seven Clubhouse programs. V also operates six residentially-based day programs. The programs are focused on skills and residents' mutual support.

Recovery and Other Peer Initiatives: In 1993, V was the first provider in the state to hire a Director of Recovery. The Director of Recovery is a member of V's senior management team and has a lived experience of mental illness. V's Director of Recovery, Lisa Halpern, provides guidance on policies and practices, works directly with staff and clients, and offers her valued perspective in staff training and as a teacher. V operates Recovery Learning Community

services, through a subcontract with Metro Boston Recovery Learning Communities, in Somerville, Plymouth, Hyannis, Fall River, and New Bedford.

Family Initiatives: For the past 16 years, V has hosted and coordinated National Alliance on Mental Illness (NAMI) Family to Family groups in several service areas. The NEA's TIP project has benefited from the successful family engagement models designed by Dr. Rusty Clark, developer of the TIP model. TIP offers practical approaches for family members on setting reasonable expectations for their loved one, the recovery and relapse processes, collaborative family problem-solving, and long-term planning.

Developmental Services Division: V offers a comprehensive array of services for individuals with intellectual and developmental disabilities, autism, visual and hearing impairments, and physical disabilities. The Developmental Services Division partners with individuals, their families, employers, and communities, to help them receive the services they need to achieve their goals and attain independence. V supports nearly 1,000 individuals in 80 service settings in Massachusetts.

Brain Injury Services: V provides a variety of services for people with acquired or traumatic brain injury, and partners with individuals, their families, providers, and communities, to assist the individual in receiving the services that will help them accomplish their goals. Integrated into V's Brain Injury services are the latest developments in clinical and rehabilitation intervention, including cognitive, behavioral, and computer-assisted technologies delivered by caring and highly trained staff.

BOSTON MEDICAL

ATTACHMENT 2

BMC ESP Quality Management Plan

Quality Management Philosophy

The BMC ESP Program is committed to a program-wide plan for Performance and Quality Improvement that focuses on improving the important functions and processes of the Program in order to

- Improve the quality of care and patient outcomes
- Enhance the value of all services provided
- Improve the Program's operational efficiency

The definition, measuring, monitoring and improvement of quality service are the responsibility not only of the Quality Management Director and QM Committee, but also of every person in the ESP Program.

We believe that there is always room for improvement in all processes, systems and services and reject the adage, "If it's not broken, don't fix it".

Decisions are based not on whim or intuition, but rather on the consideration of facts and data.

When a problem is identified, we will not jump to a solution. Instead, we will define the problem clearly; collect data to better understand the extent of the problem, its causes, and the contributing factors; based on the analysis of the data, develop a possible solution, implement it and go back later to monitor its effectiveness in solving the problem. This approach has a greater likelihood of solving the problem permanently, rather than being a "quick fix", and it can be done in a timely manner.

When we encounter a conflict or thorny issue, or when we receive a complaint, we will talk about these openly and with detail. Most often these issues are the result of a flaw in one of our systems, not the result of incompetence by an individual. Therefore, the frank discussion of issues must be viewed not as finger pointing and blame-placing, but as an opportunity to fix the system and allow the people within it to succeed.

The BEST Quality Management Program includes a focus on both Quality Assurance and Quality Improvement:
Quality Improvement examines existing work methods, processes and systems and develops ways to make them better. It is not necessarily problem-based, but rather assumes that there are always opportunities for improvement.
Quality Assurance looks to answer the question: what do you do and how do you know you're doing it well? (i.e. assuring quality)
Therefore, each component of the ESP considers:

- What do you define as your most important aspect(s) of work? What are the most important things that you do? Why are you here?
- How do you know that you're doing those things well/right? What objective data or information do you look at that tells you that?
- How do you collect that data? How often do you examine it? What performance standard (percentage or numeric threshold) have you set for your service?

In addition to each component of the service creating indicators of quality, the ESP program as a whole identifies its aspects of work which are high risk, high volume, or problematic. Quality Assurance and Quality Improvement activities and teams may be organized to address these issues; also, such issues may be referred to existing committees for exploration and problem solving.

Purpose and Goals of the Quality Management Plan

The Quality Management Plan provides a framework for a systematic, comprehensive approach to planning, measuring, analyzing, and sustaining improved performance of BMC ESP program-wide systems and processes; it supports the ESP mission of providing comprehensive emergency behavioral health services for the defined service area.

The goals of the QM Program and Plan include:

- To provide mechanisms for the identification, assessment, maintenance, and improvement of organizational performance and patient care/treatment outcomes for person served by the ESP.
- To ensure timely and practical resolution of identified problems or issues using the quality management process and principles.
- To ensure that valid and reliable data are gathered, reviewed, analyzed and utilized in the identification and resolution of problems and improvement in quality of services.
- To identify and prioritize system issues that impact the quality of patient care and of the patient's experience.
- To establish an organization-wide forum in which to pursue all identified opportunities to improve the service provided by the ESP.
- To ensure that the services provided by the ESP meet all standards and regulations set by:
    1. Department of Public Health
    2. Department of Mental Health
    3. Affiliated Managed Care Organizations
    4. Massachusetts General Laws and Regulations
    5. All other relevant licensing, accrediting or certifying bodies

Structure of the Program

Senior Management Team consists of the Department's Vice Chair for Clinical Services, ESP Medical Director, the Director of Clinical Operations for the BMC Department of Psychiatry, the Clinical Director of the ESP, and the Director of Quality/Risk Management. It functions as the executive group for the ESP program. Among its functions is the oversight of the Quality Management Program, including the prioritization of Quality/Improvement activities; initiating, overseeing and coordinating PI activities, and receiving reports and approving recommendations from PI teams

ESP Operation Group includes the ESP Medical Director, the Director of Clinical Operations for BMC Department of Psychiatry, the ESP Clinical Director, the Director of Quality/Risk Management, the Medical Directors of Psych Emergency Services from BMC and partner designated EDs, and the Managers of the UCCs. It meets weekly. This same group also comprises the **Quality Management Committee** and meets monthly in that capacity. Its functions include:

- Establish expectations and performance standards for all components of the ESP program

- Reviews volume, activity and utilization data to identify high-user clients, diversionary and hospitalization rates, barriers to accessing service, community services with high/low utilization of the ESP
- Identify opportunities for improvement based on this and other data; make recommendations to Senior Management Team regarding QI/PI activities
- Manage the PI process; ensure the implementation of processes to measure, assess and improve performance
- Resolution of problems and complaints that could adversely affect the delivery of services
- Stakeholder survey; review results and identify target areas for improvement

Advisory Committee meets bimonthly and consists of a representative group of internal and external stakeholders, e.g. the area's School Department, Police Department, Court Clinic, consumers mental health services, homeless shelters and services, DMH, DMR, DSS, DYS, etc. Issues raised by this group inform the work of the Quality Management Committee. There are separate Advisory Committees for each BMS-led ESP (BEST and Cambridge/Somerville).

The Director of Quality Management is responsible for the development and oversight of a fully integrated performance improvement/ quality management plan, which ensures the quality, appropriateness and continual improvement of services provided by the ESP program. This position supports the quality/performance work of the ESP and coordinates the activities of the aforementioned groups and chairs the Quality Management Committee. (S)he also provides Quality Improvement education and information to all components of the ESP.

Data collection and Measurement

Data collection is key in translating information into opportunities for improvement by quantifying a situation, tracking a process, identifying gaps ion performance, and in verifying whether the objectives of various improvement strategies have been met. Objective data allows us to make the best possible decisions regarding the delivery of quality services to our patients and other stakeholders.
Sources of data include:

- Weekly and monthly Activity Reports which include data on encounters by team and ED, hospitalization and diversion rates, types of services and levels of care to which patients were referred (dispositions), CSU utilization (admissions, discharges, average daily census, average length of stay, declined admissions)
- Encounter and clinical documentation on patients is website based. This allows for flexible queries and reports on a variety of metrics, including response time of teams, volume trending, demographic attributes of patients served, etc.
- Risk Management findings (e.g. incident reports, complaints)
- Internal and external customer needs and expectations
- Stakeholder and consumer satisfaction surveys
- Medical record review for quality, timeliness, appropriateness of documentation
- Case reviews to identify patterns of utilization, barriers to service, treatment outcomes, and the development of system-wide crisis plan for the patient

Methodology

On small scale, leaders of teams identify opportunities for improvement in daily work and use the PDCA cycle of QI:

- What am I trying to improve? (to define the problem)

- How will I know if my change is an improvement? (to pick the right metric)
- What change can we make?
- Then plans the change (**P**lan); carries it out on a small scale (**D**o); checks the results (**C**heck); extends the change to the whole operation with modifications as necessary (**A**ct)

When confronting larger scale issues that cross components and involve a task group or PI team, we use the FOCUS/PDCA method:

F= find an opportunity to improve

O= organize a team that knows the aspects of the existing problems; define the problem and write a problem statement

C= clarify the current process to all team members; define desired outcome and what information is needed to understand the problem, its root causes and possible solutions

U= understand the sources of variation in the process being studies; collect and analyze pertinent data

S= select the improvement action from the ones that may have been identified

Prior to implementing a new program or process, we conduct a FMEA (**F**ailure **M**odes and **E**ffects **A**nalysis). This analysis is conducted by a team consisting of the primary stakeholders of the new process/program. The team identifies all the steps involved in the proposed process/program that could fail or go wrong. Each of possible "failure modes" is assigned a numerical value, that indicates its criticality in terms of how severe it is, how detectable it would be and the probability of its happening. This process prioritizes where the team should turn its attention first. The team identifies causes and potential fixes for each of the failure modes, so that intervention can be made before the process/program is implemented. It is prospective and preventative, versus traditional approaches of analyzing events after they occur.

Annual Evaluation

The Quality Management Committee evaluates the QM Plan annually, reviewing its effectiveness in achieving the goal of assuring that the most appropriate quality of care was provided to patients. Also, the Committee:

- Reviews the annual summary report of the past year's QI/PI activities, improvements made, care delivery processes modified, and projects in process
- Defines performance indicators for the next year and numerical/percentage thresholds for each
- Identifies additional data which should be collected to demonstrate performance, the frequency of data collection and analysis,
- Makes recommendations for change to the QM plan

All findings and recommendations are sent to the Senior Management team for review and approval.

Examples of Quality/ Performance Indicators by service

Call Center

- Incidence of neither mobile team being available for an evaluation in a non-designated ED within 1 hr
- Incidence of neither mobile team being available to a community-based site within 1 hr, resulting in client being sent to an ED

Designated EDs

- Wait time to be seen by psychiatry
- Youth cases handed off the ESP following ED contact/evaluation
- Hospitalization rate
- Referrals to CSU
- Referrals to other diversionary services
- Contact with collateral treaters/ PCP

UCC Mobile teams

- Response time from when request received to when clinician begins evaluation
- Hospitalization rate
- Referrals to CSU
- Referrals to other diversionary services
- Community-based evaluation by site (residential, home, school)
- Contact with collateral treaters/PCP
- Documentation of best effort to reach parent/guardian prior to evaluation
- Children/adolescents who are boarding evaluated every 24 hours after initial evaluation

UCC Walk-in

- Client wait time to receive psychopharmacology appointment
- Contact with collateral treaters/PCP

CCS

- Rate of patients being stepped up to hospital level of care
- Contact with collateral treaters/PCP
- Follow-up appointment with treater/program scheduled to occur within 5 days

Other

- Indicators based on results of the Stakeholder Satisfaction Survey
- Evaluation of program by every member and level of the ESP, using the 360 degree method
- Focus groups of clients through RLC regarding satisfaction with services, service needs and gaps
- Stakeholder surveys through Advisory Committee
- Case reviews in Operations meeting and in Kids Services meetings
- Patient satisfaction surveys in CSU
- Sampling review of patient records by QM Director to monitor quality of documentation and appropriateness of assessment and decision-making

Examples of recent QI activities and improvements

- Implementation of Docusign system whereby backup psychiatrists can use phone or tablet to complete and sign Sect. 12 forms for clinicians in the field, following consultation with clinician. Allows document maintenance and storage as well as more timely response to request.

- Institution of monthly all-ESP trainings. Recent topics include MI/PSB; patient presenting with intoxication and SI; child sex trafficking; motivational interviewing; impact of racism on provision of MH services.
- Creation of Community Outreach Clinician in Cambridge/Somerville to analyze community demographics and services utilization to assist with targeted outreach efforts, increase ESP utilization and decrease ED utilization
- Refined handoff processes shift-to-shift within programs, and day-to-day between program components
- Increased presences of Recovery Learning Community staff in CCSs
- Medication education for RN staff in CCSs
- Increased use of youth boarding at home (vs in EDs) while awaiting CBAT placements, when deemed safe and with caregiver agreement
- Increased number of Mental Health Court sessions and number of clinicians in those courts
- Participated in MBHP-sponsored CQI consumer satisfaction effort
- Conducted a survey of BMC and MGH EDs regarding reasons patients choose EDs for care

BMC ESP Data Management Grid

Type of Report	Who's the Audience	How to Use the Information	Frequency of Reporting	Responsible Person
Response time to non-designated EDs	ESP Operations group; Senior Leadership	Identify/analyze trends and the variables which may impeded and/or facilitate response time) especially those greater than 1 hour from time patient is ready	Quarterly	Dir. QM
CCS patient satisfaction	CCS staff; BEST Senior Leadership	Identify areas of the program with which patients are/aren't satisfied; create QI action plans to improve the areas identified as in need of same	Quarterly	CCS Program Managers
Psychopharm utilization by both UCCs	Senior Leadership;	Examine patterns/trends of utilization (volume vs. capacity, no shows, initial and follow-up appointments	Monthly	ESP Clinical Dir.
Calls to Call Center which did not lead to an evaluation	Senior Leadership;	Identify volume of calls; sources of, reasons for and appropriateness of calls. Risk Management purposes	Quarterly	Call Center Dir.
Monthly Activity and utilization Reports	ESP Operations group; Senior Leadership; Advisory Committee	Describes all aspects of activity in all components of ESPs (volume, location, disposition, hospitalization rates, etc.). Allows analysis of utilization and other aspects of compliance with ESP standards	Monthly	ESP Clinical Dir.
Incident report and complaints tracking	Senior Leadership; ESP Operations group	Identify serious incidents which require immediate change in policy/procedure/process. Analyze trends to identify opportunities for improvement	Quarterly	Dir. QM
Patients boarding in EDs	ESP Operations group; Senior Leadership	Monitor volume of boarders; analyze reasons for same, with a goal of making systemic changes to decrease boarding rate	Monthly	ESP Clinical Dir.
High users of ESP services	ESP Operations group;	Identifies clients seen more than twice in a month so that Crisis Plans may be created and attempts may be made to hook client up with ongoing treatment	Monthly	UCC managers
CCS utilization	Senior Leadership; ESP Operations group	Analyze volume, LOS, trends of issues dealt with, post-discharge treatment and follow-up; allows future program modification and improvement	Monthly	CCS Nurse Mgr

CCS unplanned discharges	Senior Leadership; CCS Leadership	Analyze reasons patients leave the CCS prematurely; facilitates program improvements to decrease unplanned discharges	Quarterly	CCS Nurse Mgr
Use of diversionary services	ESP Operations group; Senior Leadership	Look at the degree to which each team is using CSU, Detox, EATS, ART, PHP, FST diversionary services	Monthly	ESP Clinical Dir.
Results of client and stakeholder satisfaction surveys	ESP Operations group; Senior Leadership; Advisory Committee	Identify areas of satisfaction and dissatisfaction with services; informs planning and decision-making for quality improvement activities	Annually	Dir. QM
Clinician profiles	Senior Leadership; UCC managers	Looks at number of encounters done by each clinician and use of diversionary services (vs. hospitalization). Sample of each clinician's case write-ups are also reviewed, for quality of assessment and documentation. Informs clinical supervision by team managers	Semiannually	Dir. QM

ATTACHMENT 3: ESP RESPONSE TIME

BEST/
Cambridge Somerville ESP
Information System
Give Us Feedback
Give me 20 more minutes

ESP RESPONSE TIME

Back to Main Menu
(Help Desk 617.271.0009)

Click Here to Log Out

Resource Directory
PsychoPharm Calendar

Start Date: 07/01/2015 End Date: 07/31/2015 Submit With New Dates

07/01/2015 through 07/31/2015

How do I read this report?

ClientID	Team	Date/Time Eval Began	Split	Location/Date/ Time of Readiness	Response Time	Readiness Time
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/01/15 06:00PM 07/01/15 07:00PM	E	At Home 07/01/15 06:30PM	1 hrs	0.5 hrs
[redacted]	BEST-BMC 800 CS ESP North Suffolk UCC	07/04/15 10:15AM 07/04/15 11:00AM	D	At Home 07/04/15 10:15AM	0.75 hrs	0.75 hrs
[redacted]	BEST-BMC 800 CS ESP North Suffolk UCC	07/07/15 02:30PM 07/07/15 03:30PM	D	At Home 07/07/15 03:30PM	1 hrs	0 hrs
[redacted]	BEST-BMC 800 CS ESP North Suffolk UCC	07/17/15 11:15AM 07/17/15 02:00PM	D	At Home 07/17/15 01:00PM	2.75 hrs	1 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/13/15 03:00PM 07/13/15 04:15PM	E	At Home 07/13/15 03:45PM	1.25 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/17/15 12:30PM 07/17/15 02:00PM	D	At Home 07/17/15 12:30PM	1.5 hrs	1.5 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/29/15 12:15PM 07/29/15 04:45PM	D	At Home 07/29/15 04:30PM	4.5 hrs	0.25 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/14/15 03:15PM 07/14/15 05:00PM	E	At Home 07/14/15 04:00PM	1.75 hrs	1 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/14/15 02:45PM 07/14/15 03:45PM	D	At Home 07/14/15 03:15PM	1 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST North Suffolk UCC	07/10/15 11:00AM 07/10/15 12:00PM	D	At Home 07/10/15 11:30AM	1 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/15/15 11:45AM 07/15/15 01:00PM	D	At Home 07/15/15 12:00PM	1.25 hrs	1 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/28/15 12:15PM 07/28/15 01:00PM	D	At Home 07/28/15 12:30PM	0.75 hrs	0.5 hrs
[redacted]	BEST-BMC 800 BEST BayCove UCC	07/30/15 09:45AM 07/30/15 11:30AM	D	At Home 07/30/15 11:00AM	1.75 hrs	0.5 hrs

ATTACHMENT 4

When and How to Request a Crisis Evaluation

Reasons to Call

- **To help determine whether the person is safe**
- **To access additional treatment**
- **To consult on what to do**

Remember: Follow your agency's crisis protocols which may include consultation with your supervisor or admin on-call

Call

1-800-981-HELP

(4357)

1 Provide your information & client's demographics

- Your Name
- Role/Relationship to Client
- Direct phone number
- **After hours or alternate contact number**
- Client's Name
- Client's Date of birth (DOB)
- Client's Social Security Number
- Client's Insurance information
- Client's Address & phone number
- Location where client will be seen
- Provider/Outpatient clinicians' names/numbers
- Any crisis plan that may exist for client

2 Describe the person's concerning behavior:

- Give specific examples of how the client is acting, e.g., making suicidal statements, stating others are out to harm him or her, staying up all night talking to people who aren't there
- Describe whether the client is cooperative and willing to be engaged **VS.** uncooperative or unaware that the ESP is being contacted
- Any known history of the client's behavior in similar situations to help understand risk

3 Safety & Risk Assessment (sample questions)

- Who is in the home/ residence with client?
- Who can be present to introduce ESP staff to the client? (Required if client does not know that the ESP is coming or is not agreeing to the visit)
- How are persons in the home/residence related to client?
- Anyone in the home who is actively using substances?
- Anyone in the home who is agitated, threatening or otherwise violent?

4 Possible outcomes:

The Call Center will help decide whether to …

a. send a **mobile clinician** to the client
b. have the client come to our **urgent care site;** or
c. whether a Section 12A to an emergency department must be considered.

STOP Call 9-1-1

For **IMMEDIATE DANGER**—call 911 in lieu of ESP (Overdose, Bleeding, Violence, Life-threatening substance intoxication or Life-threatening medical condition.)

ATTACHMENT 5: ED-SPECIFIC DIVERSION PLANS AND HOSPITAL COMMUNICATION PROTOCOL FOR CASE RESPONSE

2.3.2 ED-Specific Diversion Plans

2.3.2.1 Collaboration with Hospital

Dr. John C. Corrigan Mental Health Center

Though the DMH site at Corrigan Mental Health Center (CMHC) does not have an emergency department, it will nevertheless be important to establish a close working relationship with the site's leadership and staff. Areas to address include the impact of moving the CBL and CCS out of the center and any potential concerns DMH staff may have in working with a non-DMH ESP program.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of CMHC to discuss referrals and overall communication. The move of ESP CBL to another location will require building a close collaboration to serve those clients accustomed to receiving crisis intervention at the current ESP's CMHC site.
- Discuss and confer with center staff regarding best practices:
  - Processes for early notice of evaluations of people presenting to the center in crisis;
  - Assessing when patients under the influence of substances can be interviewed onsite;
  - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with CMHC staff across clinical, case management and PHP services to develop crisis plans with clients and processes for crisis intervention at the site.
- Work with CMHC to redirect its walk-ins to the Call Center and BC for future interventions. Help the center's staff educate users about options in the community for future use.
- Develop procedures for making timely, efficient referrals to the center's acute inpatient unit, helping to alleviate boarding situations in other area hospitals.
- Collaborate with CMHC's clinical, case management, and partial hospitalization staff in meeting with key community services regarding redirection of crisis situations to the ESP and away from hospital emergency departments such as St. Anne's Hospital or Charlton Memorial Hospital.

2.3.2.1.3 Minimizing Boarding

Not applicable for this site.

2.3.2.1.4 Rapid Response

Rapid response to CMHC will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

St. Anne's Hospital

BMC anticipates making formal arrangements with St. Anne's Hospital (SAH) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of SAH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.

- Discuss and confer with ED staff regarding best practices:
  - Processes for early notice of evaluations coupled with notification of client readiness;
  - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
  - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
  - Protocols for how B-ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case (See attached current policy in place with Boston EDs, *Hospital Communication Protocol for Case Response)*;
  - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with SAH ED to identify sources of referral to ED and develop plan for educating referral sources about ESP's community services.
- Work with SAH ED to redirect its walk-ins to the Call Center and UCC for future interventions. Help the ED staff educate users about options in the community for future use.
- Collaborate with ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.
- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using the electronic information system and refer for individualized treatment plans.

2.3.2.1.3 Minimizing Boarding

Boarding can be kept to a minimum by diligent attention to the following strategies, processes, and resources:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients.
- ED interventions will emphasize client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client.
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements.
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services (presentations at staff meeting, onsite tours of CCS programs, etc.).
- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff.
- ESP will conduct regular, thorough bed searches.
- ESP will engage in regular dialogue with SE area providers of inpatient services
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 Rapid Response

Rapid response to SAH ED will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Charlton Memorial Hospital

BMC anticipates making formal arrangements with Charlton Memorial Hospital (CMH)

Emergency Department (ED) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of CMH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.
- Discuss and confer with ED staff regarding best practices:
  - Processes for early notice of evaluations coupled with notification of client readiness;
  - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
  - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
  - Protocols for how B-ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case (See attached current policy in place with Boston EDs, *Hospital Communication Protocol for Case Response)*;
  - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with CMH ED to identify sources of referral to ED and develop plan for educating referral sources about ESP's community services.
- Work with CMH ED to redirect its walk-ins to the Call Center and UCC for future interventions. Help the ED staff educate users about options in the community for future use.
- Collaborate with ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.
- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using the electronic information system and refer for individualized treatment plans.

2.3.2.1.3 Minimizing Boarding

Boarding can be kept to a minimum by diligent attention to the following strategies, processes, and resources:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients;
- ED interventions will emphasize client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client;
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements;
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services (presentations at staff meeting, onsite tours of CCS programs, etc.);
- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff;
- ESP will conduct regular, thorough bed searches;
- ESP will engage in regular dialogue with SE area providers of inpatient services;
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 Rapid Response

Rapid response to CMH ED will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be

manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Hospital Communication Protocol for Case Response

Please maintain contact with the emergency department or medical floor referral source (the referring psychiatrist or social worker) throughout the process of arrival, evaluation and placement. Please adhere to these guidelines:

1. Page the referring psychiatrist or social worker **upon arrival** to inform that you are on site and starting your evaluation.
2. Contact them **at the point you have made your assessment** to discuss case and to collaborate upon the planned intervention. A mutually agreed upon plan is necessary.
3. Contact them **when the patient is ready for transfer** and a receiving facility/accepting physician has been identified. In some cases, it will be necessary to report that NO immediate placement is available and will be necessary for the patient to board until a later point in time....in some cases it will be necessary to involve the medical team, for example, if the receiving facility requests a nursing report, but the proper protocol is to channel these requests through the referring psychiatrist or social worker.

In general, please maintain good communication and contact throughout the process. It's especially important to remember that your main point of contact should be with the referring individual/department...It's ok to keep the other medical staff who are caring for the patients informed and updated, but your main point of contact should be with the referring psychiatrist or social worker.

Follow-up Assessments of Persons Who are Boarding

We may need to place people, but inpatient beds are not always available.

MBHP and other payers require a follow-up assessment, and it is good practice that we do one every 24 hours for anyone who is boarding and awaiting a placement.

At a minimum, such follow-up assessments need to include the following:

1. Current mental status examination, including a summary of client's behaviors over the past 24 hours and any interventions (e.g., medication, putting additional supports in place) over the past 24 hours
2. Description of alternative dispositions that were explored and results
3. Full bed search, if placement remains necessary, including referencing the use of Massachusetts Behavioral Health Access website
4. Communicate client's current status to appropriate contacts at the boarding site (e.g., consult liaison psychiatrist on medical floor, psychiatry resident in ED)
5. Communicate results of visit to the payer (e.g., MBHP) access line
6. Documentation of 1-5 above in the BEST/CSESP IT system, either as an addendum in the original encounter (adults) or Unit of Work (youth, within seven days of initial evaluation)

Clinician Checklist of Boarding Procedures

Please initial each item indicating that you have completed the listed task. Please use this as your fax cover sheet for paperwork you send to the office

BEST (617) 523-1207 CSESP (617) 616-5410

For Initial Evaluations:

____ **Exhaustive Bed Search Completed.** Bed Search thoroughly documented in the "follow-up" section, including reasons why facility declined referral

____ **Insurance Pre-certification completed and documented in the appropriate section**

____ **Labwork and other printed material faxed to BEST or CSESP office.** *On Weekends, faxed to the call center.*

____ **Written Evaluation/Electronic Record Updated** *including all pertinent components of the "client summary section" completed.*

____ **Communication with Referral Source** *Emergency Room Contacts (psych resident, attending, etc. informed of status of the placement*

For 24-hour re-evaluations

____ **Specific to MCI Cases** *all MCI (age 20 and under), all work which takes place within 7 days of the initial encounter is documented as a unit of work...not as a new encounter*
For Adult cases: *do not enter a new encounter. All follow-up notes are written in the follow-up section.*

____ **New MSE, thorough assessment, and summary of and pertinent changes since the most recent (usually the day before) evaluation is clearly documented in your written evaluation, in the "follow-up" section**

____ **Labwork and other printed material faxed to BEST or CSESP office.** *On Weekends, faxed to the call center*

____ **Communication with Referral Source** *Emergency Room Contacts (psych resident, attending, etc. informed of status of the placement*

____ **Written Evaluation/Electronic Record Updated** *including all pertinent components of the "client summary section" completed.*

____ **Insurance Company** is contacted is updated and you have documented who you spoke with. Informing them if the client is still boarded, or if they will be discharged, sent to CCS, etc.

ATTACHMENT 6: PROFESSIONAL DEVELOPMENT ACTIVITIES AND TRAININGS OVER LAST TWO YEARS

BMC trainings:

The below trainings were held at BMC over the past two years.

- Peer-Driven Recovery and Resources, Metro Boston Recovery Learning Community, various staff
- The Power of Peer Support, RLC leaders for Grand Rounds
- The Principles of Recovery and the Role of Peer to Peer Services
- Motivational Interviewing

Bay Cove trainings:

Below is a sample list of available trainings.

- Principles of Rehabilitation and Recovery
- Person Centered Planning
- Motivational Interviewing
- Development of Rehabilitation Plans
- Health and Wellness: Building a Wellness Vision
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Thomas Brown Trauma Informed Training—developed as part of a graduate program by a BC Peer Specialist, it relies on the presenter's personal experiences with trauma, as well as those of the trainees and the neurological effects of repeated trauma on the survivor

Vinfen trainings:

- Recovery Milestones (Milestones of Recovery) – 2 hours
- Co-Occurring Disorders – 3.5 hours
- Partnerships for Recovery – 4 hours
- The Practice of Psychiatric Rehabilitation – 4 hours
- Ethics and Human Rights – 4 hours
- Developing Great Wellness and Recovery Action Plans (WRAPs) – 3 hours
- Wellness Recovery Action Plan (WRAP) Facilitator Trainings – 5 day/8 hour training
- Hearing Voices That Are Disturbing – 4 hours

ATTACHMENT 7: COMMITMENT TO CULTURAL DIVERSITY

MEMORANDUM

TO: All BMC Employees

FROM: Kate Walsh, President and CEO

DATE: March 2014

RE: Diversity Statement

Boston Medical Center is proud to be an integral part of the diverse community of Boston. It is this community, comprised of people from a wide variety of cultures and backgrounds, that BMC draws upon as a resource for its employees and its patients.

As part of its stated mission and values, BMC remains committed to creating and sustaining a work place and a hospital where we respect and value employees, patients, and patients' families not in spite of, but because of, the differences in their backgrounds and cultures. We believe there is strength in diversity, not only of race, gender, age, religion, and disability, but also of education, politics, family status, national origin, sexual orientation, gender identity and/or expression and all of the other factors that make people individuals.

Honoring the diversity of our community will promote and ensure the mutual respect, collaboration, and productivity that is necessary to provide the highest quality health care.

ATTACHMENT 8

Bay Cove Urgent Care Center/CBL
RE.P.O.R.T.
(Reviewing Every Patient and Offering a Reliable Transition)

Please note the following requirements for responsible patient handoff for all people evaluated through the CBL (mobile and at the UCC).

Situation/ disposition	Communication Procedure	Documentation requirements
Day to evening clinician	• Communicate verbal information to pass the incomplete evaluation and disposition work from one C to another C where possible. • If another C not available, communicate to supervisor in charge • If another C or supervisor in charge are unavailable, communicate to Call Center staff • Reminder — with children and adolescents, be sure to review with BMC MCI (weekdays) or Attending on call (evenings and nights) • Inform patient and family if you are passing along their information and what they can expect	• Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.
Evening to night clinician	• Communicate verbal information to pass the incomplete evaluation and disposition work from one C to another C where possible. This should be accomplished by telephone. • If the night clinician has already been dispatched for another evaluation, communicate all needed information to the Call Center staff. They will pass this information along to the night on-call C when they are available. • Reminder — with children and adolescents, be sure to review with the Attending on call (evenings and nights). • Inform patient and family if you are passing along their information and what they can expect.	• Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.
Night to morning clinician	• Communicate verbal information to pass the incomplete evaluation and disposition work to the Call Center staff. This should be accomplished by telephone. The Call Center staff will pass along to day staff. • Reminder — with children and adolescents, be sure to review with the Attending on call (evenings and nights). • Inform patient and family if you are passing along their information and what they can expect	• Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.

Situation/ disposition	Communication Procedure	Documentation requirements
Clinician to ED staff	• Inform them of status of evaluation and any patient safety concerns. • Inform them about disposition or expected outcome. • Request any medical support needed (labs, etc.).	• Complete the evaluation. • Make a copy of the eval and file in the medical chart.
Clinician to CCS	• Communicate reason for admission and facilitate nurse to nurse report (if Pt was evaluated in the ED). • Secure medical clearance as needed. • Introduce patient to the CCS staff. • Notify DMH police regarding pending admission to CCS.	• Complete evaluation so that CCS staff can access through BEST IS at admission.
Clinician to patient and family	• In all circumstances where a handoff is needed, inform the patient and their family regarding what they can expect. • If the eval is done and the person returns home, inform them of follow up appointments or how to access follow up support if needed	• Include in the eval and chart. Complete discharge plan and hand to patient or family.
Clinician to community care providers	If the eval is complete and the disposition is for the person to go home or to outpatient or partial services, notify community providers by telephone.	Document collateral contacts in the pt's eval.
Clinician to Call Center stall	At end of each shift notify Call Center staff of the status of all evaluations.	Document notification in evaluation.

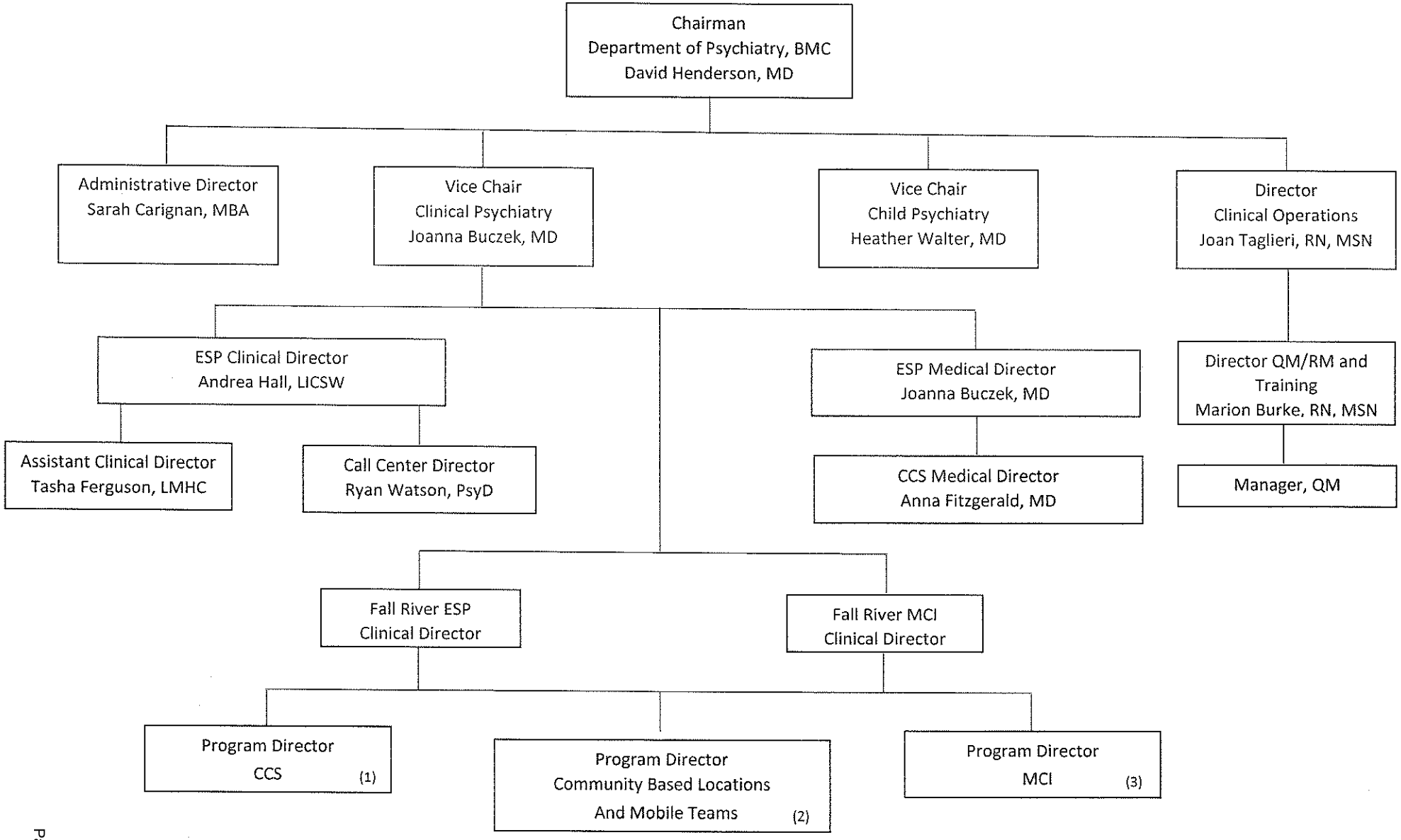
ATTACHMENT 9: BAYCOVE TRACKING SAMPLE

COLOR CODING	Awaiting call back	Any text in just BOLD is a f/u contact	On site pending cases for clients who have not arrived yet	A case that is scheduled for a future date	A case that is ready to be seen and waiting to be assigned	Scheduled community visits later (today)	Case information incorrect in BEST system	MCI hand-offs from other teams	Not seen yet but assigned
Date	**Time**	**CC Clinician**	**Client**	**Location**	**Clinician Assigned**	**Time Clinician Informed**	**x-Initials When Case Completed**	**Clinician Return/End Time**	**Notes**
6/15/2015	6:15 PM	Laurent	CT	CHB ED	Crystal				
6/15/2015	6:02 PM	Laurent	CT	bayview inn	Elie				
6/15/2015	5:05 PM	Laurent	CT	Yawkey Bldg 4th Flr	Crystal				
6/15/2015	4:24 PM	MCI hand off	CT	Dorchester	Patrick & Ashley				
6/15/2015	4:21 PM	walk in	CT	on site	Elie & Marty				
6/15/2015	3:46 PM	laurent	CT	HV Matt	Heidi				
6/15/2015	3:41 PM	Joanne	CT	Carney ED	Ben				
6/15/2015	3:23 PM	Daphna	CT	on site	alex & marty				
6/15/2015	2.14pm	paul	CT	campus)	Alex				
6/15/2015	1:43 PM	Joanne	CT	on site 3-3:30 PM	Jaime/Ashley				
6/15/2015	1:11 PM	Don	CT	Dorchester-Grp Home	Heidi				
6/15/2015	12:44 PM	Paul	CT	HV Dorchester	Erin				
6/15/2015		MSE	CT	CHB 9E	no longer considering d/c for today see UOW				
6/15/2015		MSE	CT	CHB ED	Cancelled				
6/15/2015		MSE	CT	CHB ED	Michael				
6/15/2015		MSE	CT	CHB ED	Michael				
6/15/2015		MSE	CT	CHB 9NE	Michael				
6/15/2015		MSE	CT	CHB 7W	Michael				
6/15/2015		MSE	CT	CHB 6NE	Michael				
6/15/2015	11:24 AM	Paul	CT	Carney 3NE	Ben				
6/15/2015	11:24 AM	Paul	CT	ICU Carney	Francesca 2				
6/15/2015	11:09 AM	Joanne	CT	ICU Carney	Francesca 3				
6/15/2015	11:09 AM	Joanne	CT	Carney [moving from ICU to 3NE]	Ben				
6/15/2015	10:58 AM	Paul	CT	Coomunity Accademy Dorchester	Mike				
6/15/2015	10:30 AM	Walk-in	CT	on-site	Olga/Marty				
6/15/2015	10:08 AM	Paul	CT	The Spot--Roxbury	Heidi				
6/15/2015	10:07 AM	walk in	CT	On-site	Jaime/Olga				
6/15/2015	9:15 AM	Walk in	CT	On-site	Erin				
6/15/2015	9:15 AM	Joanne	CT	Carney	Francesca 1				
6/15/2015	9:00 AM	Don	CT	onsite	Erin				

ATTACHMENT 10: ESP DIRECTOR QUALIFICATIONS

- Level of knowledge equivalent to Master's degree in Psychology, Social Work, Nursing or in Counseling. Requires current Massachusetts Licensure.
- Minimum of five to seven years of supervisory experience in a psychiatric setting. Experience in the provision of emergency services strongly preferred.
- Demonstrated clinical and supervisory skills.
- Demonstrated ability to work with key stakeholders, including funders, subcontractors, state agencies
- Ability to provide leadership and coordinate the work of a team of assigned team members.
- Excellent oral and written communication skills; ability to be detailed oriented in all notes and documentation.
- Demonstrated ability and experience in areas such as grant management, training, team building, program development/management, problem solving, and community building.
- Ability to analyze needs and apply resources effectively to meet those needs.
- Ability to achieve targeted results through motivating, mobilizing, and delegating to others.
- Ability to work in a multicultural environment.
- Experience with Windows, Word, Excel, Outlook, Internet and web page usage/updating, social networking and other technologies that can be used to further carry the program's mission.

Attachment 13: Boston Medical Center Fall River Emergency Services Program Organizational Chart



(1) Services Provided by Vinfen and BMC Psychiatry
(2)(3) Services provided by Bay Core Human Services

ATTACHMENT 14: RESPONSE TO REQUESTS FOR COMMUNITY-BASED EVALUATION IN SITUATIONS FELT TO BE DANGEROUS

BOSTON MEDICAL CENTER

DIVISION OF PSYCHIATRY
BEHAVIORAL HEALTH SERVICE
BMC BEST/ Cambridge-Somerville ESPs

Policy: Response to Requests for Community-based Evaluation in Situations Felt to Be Dangerous
Policy number: 023
Date issued: 11/05
Date revised:
Date reviewed: 5/10

Mission Statement and Non-Discrimination Policy:
We will provide consistently excellent and accessible health service to all in need of care, regardless of status or ability to pay. Patients' diversity is respected and we are sensitive to ethnic, cultural, gender, sexual orientation, and religious differences.

Purpose of Policy:
To define the process to be followed when BEST/C-S ESP receives a request to perform a community-based evaluation and the BEST clinician raises a question of potential danger in meeting such a request.

Scope of Policy:
All team members within the BEST/C-S ESP program

Substance of Policy:
If the BEST/C-S ESP Call Center receives a request to perform an evaluation in the community (e.g. a home) that is felt by the Call Center clinician and/or the Mobile Team clinician to pose a potential threat to the clinician's safety (or to the safety of the person him/herself, a family member or other person in the situation), the clinician in question will call his/her supervisor who will contact the Clinical Director of the BEST/C-S ESP Team to discuss the particulars of the situation. If necessary, the Clinical Director will confer with the Medical Director. Following discussion, a determination of how to respond shall be made. . If the Clinical and Medical Directors feel that it is unsafe for the clinician to respond to the community site, several options are possible:

- Provide a two-person response if this is sufficient to alleviate safety concerns
- the requester of the evaluation will be directed to have the patient brought to BMC Emergency Department for BEST and Cambridge Hospital PES for CSESP

- the Call Center at BMC can assist with a Section 12 for instances in which the client's presentation is the source of the safety concern and Section 12 criteria is met
- the BEST/C-S ESP Team will request that a member of the Police force meet them at the site as stand-by

A log of requests not met due to the danger posed shall be maintained by the BEST Call Center. This shall also be documented in the patient's electronic record, generated when the call is received by the Call Center.

Documentation Requirements:
As described above

Implementation:
The Clinical Director of the BEST/C-S ESP Team is responsible for the implementation of this policy.

Policy Review:
The Director of Quality/Risk Management for the BEST/C-S ESP Program shall ensure biannual review of this policy.

ATTACHMENT 15: CHILD-FOCUSED TEAM DESCRIPTION

BEST and CS-ESP mobile teams (as well as MCI teams across the state) have the ability to provide up to 7 days of service to youth under age 21 and their families following an initial encounter. This increase from the former 72 hour standard was initiated by the MassHealth Office of Behavioral Health with the intention of providing greater opportunities for stabilization in the community to youth and families experiencing crisis.

The mobile team offices (BayCove, NorthSuffolk, and Cambridge/Somerville) house a Child Focused Team, which monitor youth follow-ups in the community, and ensure a high standard of care for both planning and carrying out interventions. Each Child Focused team consists of a youth team leader, full-time clinician(s), and family partner(s) who work together to meet the needs identified by the youth and family.

- The system for triaging and responding to requests for new evaluations remains unchanged—the Child Focused Team will be primarily responsible for providing interventions to youth and families after the point of the initial evaluation, including MCI Hand-offs from the EDs;
- ED staff can continue to request community-based follow-up for youth clients through the BEST Call Center;
- When documenting CBHI-eligible cases (MassHealth and uninsured clients) please open a new encounter **only every 7 days**, using units of work to document activity on days 2-6; and
- For non-CBHI eligible cases (Harvard Pilgrim and Commonwealth care clients) please open a new encounter daily—as with adult clients—and **do not use units of work**.

This expanded length of service to youth and families gives an exciting opportunity for BEST and CS-ESP to continue to provide more comprehensive community-based care, thereby allowing families to be served in the least restrictive and most individualized way possible.

ATTACHMENT 16: YOUTH CONSULTATION PROTOCOL

BEST/CSESP On-Call Consultation Protocol for Youth (age 0-20) – for Mobile Teams

This protocol assures that every youth case will be reviewed with a licensed supervisor, ***either*** at the BMC attending level or mobile team supervisor.

1. Review with BMC Attending

The BMC attending (weekdays – clinical director or MCI manager; off-hours – psychiatrist) should be contacted in real time for youth encounters when they involve any of the following:

- The initial complaint alleged acute safety issues – e.g., suicidal ideation, homicidal ideation, or question of psychosis
- The clinician wants to refer the youth to a 24-hour level of care
    - This would include youth who will board in the community awaiting CBAT
- Review for issuing Section 12A
- For youth 18 and older, review for CCS placement **(with CCS APRN weekdays)**
- The evaluating clinician has not been able to reach consensus about disposition with youth, family and collaterals, and the situation cannot be resolved at the team supervisor level (e.g., Doc-to-Doc is required; MCI Manager needed to provide guidance)
- All individuals being discharged to community from Somerville ED and Carney ED.
- Medical-related questions
- 51A filings against a program or employee of a program
- On an as-needed basis; clinicians should always feel free to seek consultation from the BMC attending

2. Review with Mobile Team Supervisor

When **ALL** the following conditions are met, the clinician will review with licensed mobile team supervisor and is not required to contact the BMC attending:

- No acute risk factors have been reported
- A 24-hour level of care is not indicated
- All parties to the evaluation are in agreement about the proposed disposition and follow-up
- 51A filings except as described above

ATTACHMENT 17: YOUTH BOARDING PROTOCOL

BOSTON MEDICAL CENTER

DIVISION OF PSYCHIATRY
BEHAVIORAL HEALTH SERVICE
BMC BEST/Cambridge-Somerville ESP Program

Policy: Boarding Youth in the Community

Policy number:
Date issued: 12/10
Date revised: 8/15

Mission Statement and Non-Discrimination Policy:
We will provide consistently excellent and accessible health service to all in need of care, regardless of status or ability to pay. Patients' diversity is respected and we are sensitive to ethnic, cultural, gender, sexual orientation, and religious differences.

Purpose of Policy:
To define the standards and procedures for managing and maintaining safety of a youth boarding in the community as they await a 24 hour level of care placement

Scope of Policy:
All components of BEST and Cambridge-Somerville ESPs

Substance of Policy:
Whenever a decision is made by the ESP mobile team that a youth waiting for a bed in a 24-hour level of care may be safely managed in the community until placement in that bed, the procedure outlined below shall be followed.

Procedure:
The following steps shall be taken by MCI/mobile team clinicians following the decision to maintain a youth in the community as s/he awaits placement in a 24-hour level of care:

- Review the clinical assessment of the youth with the designated attending psychiatrist on-call and obtain that psychiatrist's agreement to community boarding
- Document the details of the initial bed search that resulted in the need to board the youth. If a bed had been available, but parent/guardian declined that placement, include that fact and the reason for the declination in the documentation
- Document the guardian/family and receiving facility's agreement to the community boarding plan. Complete a Youth Risk Management Safety Plan,

detailing a plan for safely managing the youth for the duration of community boarding

- In the web-based clinical encounter, check client boarding box and indicate "community" in answer to the query, "If boarded, where?"
- In the "follow-up" section of the encounter, specify the following:
    - Youth must be reassessed daily for purpose of assessing safety and for determination that 24-hour level of care is still appropriate. These reassessments shall be documented as a Unit of Work until the youth is placed or a period of 7 days has passed. A new encounter shall be completed after 7 days of community boarding.
    - All other interventions by clinicians or family partners that occur within the 7 days shall also be documented as Units of Work.
    - A bed search shall be conducted every shift during the boarding period And shall be documented as a Unit of Work
- During daily MCI rounds, the responsible team shall discuss all youth boarding in the community
- Each time the decision is made to board a youth in the community, the responsible clinician shall notify the Medical Director for ESPs, Joanna Buczek, MD, (Joanna.Buczek@bmc.org) by email. That clinician shall also copy the email to the respective team's Youth Director/Team Leader and to the MCI Program Manager (Tasha.Ferguson@bmc.org). In the email, include
    - Name of youth
    - Exact name of where boarded (e.g. home, with address; name/address of group home or other facility)
    - Indication that a Risk Management Safety Plan was completed and was left with the family or facility staff member

Documentation Requirements:
As described above

Implementation:
The Clinical Director for ESPs and the MCI Program Manager are responsible for the implementation of this policy.

Policy Review:
The Director of Quality/Risk Management for the BEST Program shall ensure biannual review of this policy.

ATTACHMENT 18: MCI HAND-OFF

CHECKLIST FOR HAND-OFFS BETWEEN BEST/CSESP Designated EDs, CALL CENTER, and MOBILE TEAMS

Responsibilities of ED clinicians

- Prepare family for follow-up
- Clearly state purpose of MCI intervention in the encounter recommendations (e.g., ongoing safety assessment, involving Family Partner to support parent)
- Triage hand-off with Call Center (1-800-981-4357)
- Provide full encounter
    - Goal: simultaneous entry in BEST/CSESP electronic system
    - If not in electronic system, fax paperwork to Call Center

Responsibilities of Call Center

- Write triage in BEST/CSESP IT system
- **It is particularly important to get all contact information to ensure successful follow up.**
- Use "Handoff to MCI" as primary disposition
- Use appropriate mobile team as "disposition where"
- Request of ED clinician calling that encounter be entered simultaneously in electronic system
    - Obtain faxed copy of assessment if not available yet in BEST/CSESP system
- Convey hand-off to appropriate mobile team child focused team via e-mail—see ***Attachment A*** for list of e-mails by team
    - Hand-offs for next day will be held on Call Center follow-up board
- Provide faxed evaluation to mobile team, only if not in electronic system

Responsibilities of Mobile Team

- Arrange follow-up as requested in encounter recommendations
- Monitor and take ownership of MCI cases until resolved
- If case will require weekend response/contact, be sure to "loop" back to Call Center for coordination of weekend follow-up
- Review status of all hand-offs with MCI Manager during rounds

Position Description: Child Focused Clinician

Responsibilities:
The BEST Urgent Care/Mobile Team provides direct services to children and adults in crisis through assessment of each person's need for services and development of a treatment plan that best ensures for their safety and optimizes effective resolution of the crisis. Facilitates the person's engagement or re-engagement in behavioral health services through referral to community based services that are consonant with the person's needs and preferences. As needed, the Clinician facilitates the person's admission to acute treatment services.

In addition to responsibilities of the general service noted above, the Child Clinician focuses on nuanced interventions with youth and families. Youth under the age of 21 are eligible for Mobile Crisis Intervention (MCI), which is a short-term service for those experiencing a behavioral health crisis that focuses on stabilization and reduction of risk. The role of the Child Clinician is to carry out the ongoing follow up associated with the intervention for up to seven days. Responsibilities include:

- Engagement in an ongoing crisis planning process
- Advance communication with treatment providers, schools, natural supports, and other youth-serving systems
- Referrals/linkages to behavioral health services and supports
- Telephonic and/or in person therapeutic response to the youth and their family

Qualifications:
Licensed Master's level clinician. License eligible acceptable. Minimally 3 years experience working in a mental health setting. Excellent writing and oral communication skills. Current Massachusetts Driver's License and use of reliable personal vehicle for work related travel.

BAY COVE HUMAN SERVICES, INC.

Position Title: BEST Mobile Crisis Child Team Leader

Department: BEST

Reports To: Service Director, BEST

Mission Statement:
Our Mission is to provide high-quality services to children and adults who face the life-long challenges of mental illness, drug and alcohol dependency, and developmental disabilities.

Job Summary:
The BEST Mobile Crisis Child Team Leader provides direct services to children and adults in crisis. This Clinician assesses each person's needs for services and develops a treatment plan that best ensures for their safety and optimizes their effective resolution of the crisis. S/he facilitates the person's engagement or re-engagement in behavioral health services through referral to community based services that are consonant with the person's needs and preferences. As needed, the Child Team Leader facilitates the person's admission to acute treatment services.

The Clinician works as part of an Urgent Care Center that provides on site assessment and support, as well as mobile capacity to conduct assessments at the person's home, school, or agency in Greater Boston. S/he works as a partner in an integrated urgent care/emergency support services network (and as a result may provide services in the CSU or sister Urgent Care Center/Mobile Team). Given the nature of crisis services, provision of holiday and weekend coverage are expectations for staff working in this position. This position is non-exempt.

Essential Functions of Position:

- Ensure completion of tasks, follow up, and case assignments pertinent to MCI (Mobile Crisis Intervention)
- Conduct assessments and provide oversight of ongoing case management of active MCI cases
- Provide support to Service Director and Assistant Program Director with supervision of staff, supervision and training of students in busy Urgent Care Center/Mobile Crisis Service (affiliation with B.E.S.T.)
- Sharing of administrative on call in rotation with Service Director/Asst. Director (24/7/365 coverage).

- Provides services in a manner that is consonant with program, BayCove, and collaborative agencies' standards, policies, and procedures
- Completes assessments of children and adults who are in crisis in a comprehensive manner attending to their safety and needs
- Develops treatment plans with and for the person in crisis that utilize community based health, behavioral health, and social services that will ameliorate the presenting crisis
- Works with the person in crisis and their support network to fortify their strengths and coping skills
- Works collaboratively with members of the BEST team and collateral helpers in the service of strengthening and integrating support and treatment supports and to accomplish the overall program's mission
- Assists the person in crises with engagement or reengagement in needed services
- Documents all assessments and interventions in accordance with program and BayCove standards
- Secures as needed financial and insurance related information to facilitate billing and payment for services rendered
- Recognizes the importance of individual and cultural differences that influence behavior and applies such understanding to each person's situation
- Utilizes individual supervision and team meetings in the service of optimizing the program's overall mission
- Maintains requisite continuing professional education as required by licensure, professional standards and BayCove policies
- Works effectively with police, DSCFMHC Security, and other law enforcement personnel to ensure the client's safety
- Facilitates admission to acute inpatient care on an as needed basis
- Relates to clients, family members, and colleagues in a professional, hopeful, and respectful manner
- Provides brief treatment and support until requisite community services can be accessed in order to minimize reliance on acute inpatient services
- Performs all other duties and projects as assigned by the Program Director.

Job Responsibilities/Job Related Competencies and Skills

- Demonstrated assessment and treatment skills in the provision of emergency services for children and, as needed, adults.
- Demonstrated ability to de-escalate crises in a manner that ensures safety for all involved and provides for the best care and welfare of the person in crisis
- Able to assess needs and implement interventions in accordance with best practice standards for emergency care, crisis resolution, and recovery
- Demonstrated professional writing, communication, and organizational skills

- Ability to assess crisis emergency situations and address with appropriate clinical treatment for clients.
- Demonstrated knowledge of risk assessment specific to acute psychiatric conditions for children and adults.
- Demonstrated assessment and treatment skills in the provision of emergency services for children and adults
- Demonstrated knowledge of varying social and behavioral health services and the nature of the treatment, rehabilitation, and supports that they offer. Can determine the persons needs for services, refer to the appropriate resource(s), and facilitate the person's engagement in these services
- Demonstrated knowledge of the evaluation process, including presenting problem, social, family, psychiatric, legal, and medical history. Capacity to effectively assess mental status, formulate a plan, and develop an implement an appropriate disposition for all clients
- Demonstrated ability to identify needs and strengths, assist in planning, implementing and evaluating care of individuals and their families in conjunction with an array of community resources.
- Demonstrated professional documentation skills

Physical Requirements

- Must be able to drive to different locations.
- Must have the ability to assess children and adults in their homes and apartments with stairs.
- Must be able to observe the person in crisis, noting symptoms and nonverbal behaviors

Qualifications:

- Licensed Master's level clinician.
- Minimally 3 years experience working in a mental health setting.
- Excellent writing and oral communication skills.
- Current Massachusetts Driver's License and use of reliable personal vehicle for work related travel

Personal Characteristics:

- Demonstrated ability to work in a pressured situation and maintain clarity, focus, judgment, and compassion
- Flexibility
- Ability to work with people in crisis in a hopeful and compassionate manner
- Ability to communicate concerns effectively to other team members and ask for help as needed
- Ability to work independently

This job description is intended only to provide general guidance. It is understood that the position may evolve over time, and that additional or different duties may be added at management's discretion. It is the policy of Bay Cove Human Services, Inc., to review and update job descriptions annually; however, updates or revisions may occur within a given year as indicated.

Division: Boston Emergency Services Team
Category: Professional - Other
Program: BEST UCC
Position: Family Partner
Requires resume: Yes
Requires Professional License: No

Responsibilities: The Family Partner works with other members of the ESP Urgent Care and Mobile Crisis teams and provides peer support to parents served by the program. Peer support is defined as using personal and professional life experiences to establish credibility and infuse hope for a better future, to demonstrate unconditional acceptance, and to assist with problem solving. Additionally, the Family Partner serves as a "values speaker", specifically, but not limited to providing a parent's perspective in the routine operations and development of the program. The Family Partner uses personal and professional life experience to provide consultation and training for staff and others to increase awareness and improve the effectiveness of parent-professional partnerships to meet the needs of families, and to participate in program and community meetings to maximize parent voice, choice, and involvement throughout the service delivery process.
The family partner will be involved in the ongoing follow up for families served by the mobile team. This includes telephonic and face-to-face interventions, identifying resources for families, initiating referrals in service of establishing wrap around supports, and acting as a liaison with current providers, schools, and state agencies.
The parent partner provides parents and caregivers with information about the ESP and the wraparound process and resources to assist them to successfully engage; Learns the family's story, culture, strengths, and concerns; Provides non-judgmental, unconditional support to parents and caregivers; Participates in implementing a variety of support services for parents/care givers; Produces and maintains accurate and timely documentation.

Qualifications: ***-Lived experience as the primary caregiver for a youth who has received mental health or behavioral health services.*** This can be as a biological parent, foster parent, or another familial relationship in which the applicant is in a primary parental role.
-Ability to work collaboratively as a member of multi-disciplinary and cross-functional teams.
-Demonstrated ability to work in a pressured situation and maintain clarity, focus, judgment, and compassion
-Ability to work with people in crisis in a hopeful and compassionate manner and

model this for others
-Ability to work independently
-Basic computer skills
-Language capacity strongly preferred

Drivers License Required: Yes

Hours:

TBD

Schedule:

40 hrs, some weekend/evening/holiday coverage

Salary: TBD

New Position: No

Employee Signature: _____

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JOB TITLE:	Program Director, Youth Mobile Crisis Intervention	**DEPARTMENT:**	Psychiatry
CODE:	50001021	**FLSA STATUS:**	Exempt
REPORTS TO:	Clinical Director, BEST and CSESP	**GRADE:**	M16A
SUPERVISES:	Clinical: Masters Level Trainees; Unlicensed Masters Level Clinicians Administrative: staff and trainees	**DATE:**	05/26/2009
BLDG/LOCATION:		**UNION STATUS:**	Non-Union

APPROVALS
DIRECTOR: _____ VP: _____ HR: _____

POSITION SUMMARY:

Manages clinical operations for youth for Emergency Service Programs (ESPs); provides clinical care to children and adolescents; provides teaching and supervision to staff clinicians and trainees; acts as liaison with internal and external entities; engages in mental health advocacy activities.

ESSENTIAL RESPONSIBILITIES / DUTIES:

Works collaboratively with Clinical Director of ESPs and the Medical Director of ESPs to create and manage a seamless system of child mental health services for Boston Medical Center's emergency services programs.

1. Plays a key role in developing the vision, mission, and strategic objectives of BMC ESP services for youth.
2. Works collaboratively with ESP leadership to create seamless coordination between emergency, crisis stabilization, urgent care, outpatient, and consultation services in child psychiatry.
3. Manages the day-to-day clinical activities of the ESPs in relation to youth, including assessment, treatment, transfer, and discharge of patients.
4. Together with the Clinical Director of ESPs and Director of QM/RM, develops and implements quality initiatives, including staff training, medical record audits, monitoring/reporting of significant clinical events, monitoring/recording patient/family satisfaction, and monitoring/recording satisfaction of referral sources.
5. Manages complaints from all key constituent groups; triages complaints to Medical Director and Clinical Director of ESPs as indicated.
6. Provides clinical care in outpatient, urgent care, crisis stabilization, emergency, and consultation settings.
8. Together with the Clinical Director of ESPs, functions as a key clinical liaison with BMC child psychiatry and pediatric services.
9. Together with the Clinical Director of ESPs, functions as a key clinical liaison with MBHP, DMA, DMH, DSS, DYS, and other state and city agencies.
10. Together with the Clinical Director of ESPs, meets with key stakeholders to communicate the vision, mission, and strategic goals of the program.
11. Together with the ESP programs, maintains an up-to-date listing of and liaison with mental health service providers, including hospitals, family stabilization teams, outpatient facilities, residential facilities and shelters.
12. Maintains an up-to-date listing of and liaison with social service resources for families.
13. Together with the Clinical Director of ESPs, Medical Director, and Director of QM/RM, develops policies and procedures for outpatient mental health services; facilitates adherence to policies and procedures among clinical staff.
14. Facilitates compliance with all regulatory imperatives, including Joint Commission, hospital, and professional.
15. Maintains personnel files for all clinical staff, including current CV, current job description, core competency ratings, mandatory education requirements, continuing education requirements, and yearly performance evaluation/goals and objectives.
16. Monitors clinician productivity on a monthly basis; creates action plans to address productivity deficits.
17. Participates in key administrative, quality management, and clinical leadership committees.
18. Together with the Clinical Director of ESPs and ESP leadership, creates orientation and training programs for ESP staff.
19. Together with the Clinical Director of ESPs and ESP leadership, hires, orients and evaluates staff performance.
20. Together with the Medical Director, provides orientation to trainees around program policies and procedures.
21. Provides clinical supervision to master's level trainees and unlicensed masters level clinicians as assigned.
22. Manages office space.
23. Maintains time off records for staff clinicians.
24. Maintains clinician work schedules.
25. Conforms to hospital standards of performance and conduct, including those pertaining to patient rights, to ensure that exceptional customer service and patient care may be provided.

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26. Utilizes hospital's values as the basis for decision-making and to facilitate the hospital's mission.
27. Follow established hospital infection control and safety procedures.

OTHER DUTIES:
Perform other duties as needed.

(The above statements in this job description are intended to depict the general nature and level of work assigned to the employee(s) in this job. The above is not intended to represent an exhaustive list of accountable duties and responsibilities required).

JOB REQUIREMENTS

EDUCATION:

Masters degree in Social Work.

CERTIFICATES, LICENSES, REGISTRATIONS REQUIRED:

Current Social Work licensure in the Commonwealth of Massachusetts

EXPERIENCE:

Minimum of five to seven years of clinical and supervisory experience in a psychiatric setting

KNOWLEDGE AND SKILLS:

1. Demonstrated clinical, supervisory, collaborative, team building, and interpersonal skills.
2. Demonstrated skill in the provision of services in a multicultural environment.

AGES OF POPULATION SERVED:

Employees in this position must be competent to provide care to the following age groups: Check all that apply:

☐ Neonatal: Birth to 1 month	☐ Infant: To 1 yrs	☑ Toddler: 1 to 3 yrs	☑ Pre-school: 3 – 6 yrs
☑ School age: 6 – 12 yrs	☑ Adolescent: 12 – 18 yrs	☐ Young Adult: 18 – 30 yrs	☐ Middle age: 30 – 60 yrs
☐ Elderly: 60 – over	☐ Not Applicable		

SPECIAL WORKING CONDITIONS (RESPONSIBLE FOR ON-CALL, 24 HR. COVERAGE, ETC.):

External and internal applicants, as well as position incumbents who become disabled as defined under the Americans With Disabilities Act, must be able to perform the essential job functions (as listed) either unaided or with the assistance of a reasonable accommodation to be determined by management on a case-by-case basis.

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PHYSICAL AND ENVIRONMENTAL DEMANDS

This form is used to assist departments in identifying the physical and environmental demands of the position .

Physical Demands Without Accommodations	Hours at one time 0	<1/2	½-1	1-2	2-4	Total Hours per day <1	1-2	2-4	4-6	6-8
Sitting					√				√	
Walking		√				√				
Standing		√				√				
Bending Neck		√				√				
Twisting Neck		√					√			
Bending Waist (Forward or sideways)		√				√				
Twisting Waist		√				√				
Squatting	√					√				
Climbing	√					√				
Kneeling	√					√				
Crawling	√					√				
Repetitive Movement: Hand		√							√	
❑ Simple grasping: 1 hand__ both__		√						√		
❑ Power grasping: 1 hand__ both__	√					√				
❑ Fine Manipulation: 1 hand__ both__	√					√				
❑ Pushing/Pulling: 1 hand__ both__	√					√				
Reaching above shoulder height	√					√				
Reaching below shoulder height	√					√				
Moving items weighing up to 10 lbs.		√				√				
Moving items weighing 11 – 25 lbs.		√				√				
Moving items weighing 26 – 50 lbs.	√					√				
Moving items weighing 51 – 75 lbs.	√					√				
Moving items weighing 76 – 100 lbs.	√					√				
Moving items weighing over 100 lbs.	√					√				

Environmental Demands (Check all that apply)

- ❑ Extreme Cold (below 32 degrees) Source_____
- ❑ Extreme Heat (above 100 degrees) Source_____
- ❑ Noise (Need to shout to be heard) Source_____
- ❑ Vibration Source_____
- ❑ Exposure to dust, gas, fumes, steam, chemicals Source_____
- ❑ Work outdoors (no effective protection from weather)
- ❑ Work at heights (such as scaffolding or ladders)
- ❑ Protective equipment required (Respirator, earplugs, mask, gloves, eyewear, etc) _____
- ❑ Potential exposure to infectious diseases.
- ☑ None (Not substantially exposed to adverse environmental conditions).

Technology Response Attachments

Fiscal Response Attachments

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 1 **ORGANIZATION:** FALL RIVER- ONE AREA **FY END:** 2016

This schedule provides supplemental information for selected programs on an aggregated basis for use by the Commonwealth's Division of Health Care Finance and Policy in the establishment of so called "Class Rate" prices for certain Me

1. UFR Program Numbers providing Mental Health Class Rate Services:

2. Program Staff and Expense Breakout by Service Component

Note: Schedule B positions not listed below are non-reimbursable for MH Class Rate services.	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE		ESP Admin	
	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS
1S Program Director	0.75	60,571	0.080	7,200	0.250	18,821	0.120	10,575	0.050	4,725	0.25	19,250
2S Program Function Manager	0.78	53,780	0.025	2,500	0.100	10,030			0.250	16,250	0.40	25,000
3S Assl. Program Director	1.00	62,204	0.320	19,905			0.470	29,236	0.210	13,063		
4S Supervising Professional	1.50	93,306	0.175	10,886			0.325	20,216	1.000	62,204		
5S Psychiatrist	0.10	22,000									0.10	22,000
7S N.P., Psych N.,N.A., R.N.- MA	0.50	60,000			0.500	60,000						
8S R.N. - Non Masters	1.00	70,266			1.000	70,266						
9S L.P.N.	3.20	130,134			3.200	130,134						
11S Occupational Therapist	0.00	0										
21S Psychologist - Doctorate	0.00	0										
22S Clinician-(formerly Psych.Masters)(UFR Title 1;	1.00	53,500									1.00	53,500
23S Social Worker - L.I.C.S.W.	6.83	367,830	2.175	117,037			3.200	172,589	1.450	78,204		
24S Social Worker - L.C.S.W., L.S.W	0.00	0										
25S Licensed Counselor	0.00	0										
26S Cert. Voc. Rehab. Counselor	0.00	0										
28S Counselor	0.00	0										
29S Case Worker / Manager - Masters	1.00	54,139			1.000	54,139						
30S Case Worker / Manager	0.00	0										
31S Direct Care / Prog. Staff Superv.	0.00	0										
32S Direct Care / Prog. Staff III	0.00	0										
33S Direct Care / Prog. Staff II	6.90	226,324	0.600	22,051	4.200	127,096	0.400	14,700	1.700	62,477		
34S Direct Care / Prog. Staff I	0.00	0										
35/36S Prog. Sec/Clerical/Maint./H-GrndsKeep.	0.75	23,772	0.250	7,924	0.500	15,848						
38S Dir,Care O.T., Shift Differential & Relief	XXXXXX	0	XXXXXX		XXXXXX		XXXXXX		XXXXXX		XXXXXX	
39S **Total Direct Program Staff**	25.30	1,277,826	3.625	187,503	10.750	486,334	4.515	247,316	4.660	236,923	1.75	119,750
2E Chief Executive Officer	0.00	0										
3E Chief Financial Officer	0.00	0										
4E Accting/Clerical/Support	0.50	22,500									0.50	22,500
5E Admin Maint/House-Grndskeeping	0.00	0										
6E **Total Admin Employee FTE/Exp.**	0.50	22,500	0.000	0	0.000	0	0.000	0	0.000	0	0.50	22,500
7E Commercial Products & Svs/Mkting	0.00	0										
8E **Total FTE/Salary/Wages**	25.80	1,300,326	3.625	187,503	10.750	486,334	4.515	247,316	4.660	236,923	2.25	142,250
9E Payroll Taxes 150		83,046				33661		32,382		17,003		
10E Fringe Benefits 151		214,011				56957		58,626		30,784		67,644
11E Accrual Adjustments		0										
12E **Total Employee Compensation & Rel. Exp.**		1,597,383		187,503		576,952		338,324		284,710		209,894
13E Facility and Prog. Equip.Expenses 390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
14E Facility & Prog. Equip. Depreciation 391				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
15E Facility Operation/Maint./Furn.390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
16E Facility General Liability Insurance 390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
17E **Total Occupancy - Allocated**		138,740		Expense		138,740		Dollars		Dollars		Dollars
18E Direct Care Consultant 201		92,900										92,900
19E Temporary Help 202		7,500				7,500						
20E Clients and Caregivers Reimb./Stipends 203						0		0		0		0
21E Subcontracted Direct Care 206												
22E Staff Training 204		8,808				7,658		863		288		0
23E Staff Mileage / Travel 205		11,160				5,040		4,590		1,530		0
24E Meals 207		14,126				14,126						0
25E Client Transportation 208						0						0
26E Vehicle Expenses 208						0						0
27E Vehicle Depreciation 208						0						0
28E Incidental Medical /Medicine/Pharmacy 209		1,800				1,800						0
29E Client Personal Allowances 211						0						0
30E Provision Material Goods/Svs./Benefits 212						0						0
31E Direct Client Wages 214						0						0
32E Other Commercial Prod. & Svs. 214						0						0
33E Program Supplies & Materials 215		11,000				6,000		3,750		1,250		0
34E Non Charitable Expenses						0						0
35E Other Expense						0						0
36E **Total Other Program Expense**		147,294		0		42,124		9,203		3,068		92,900
42E Other Professional Fees 410		21,500				0		0		0		21,500
43E Leased Office/Program Office Equip.410;390						0		0		0		0
44E Office Equipment Depreciation 410						0		0		0		0
46E Program Support 216		28,800				18,204		7,947		2,649		0
51E **Total Direct Administrative Expense**		50,300		0		18,204		7,947		2,649		21,500
52E Admin (M&G) Reporting Center Allocation		226,647				79,820		61,117		31,645		54,065
53E **Total Reimbursable Expense**		2,160,364		187,503		855,840		416,591		322,072		378,359
54E Direct State/Federal Non-Reimbursable Exp.						0		0		0		0
55E Allocation of State/Fed Non-Reimbursable Exp.						0		0		0		0
56E **TOTAL EXPENSE**		2,160,364		187,503		855,840		416,591		322,072		378,359

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 2 ORGANIZATION: FALL RIVER- ONE AREA FY END: 2016

3. Service Statistics

Total Standard Unit Hours: 0

	CBL	CCS	ADULT MOBILE	CHILD MOBILE
Number of Weeks Service was in Operation (e.g., 52):				
Defined Unit:				
Number of Defined Units Provided:				
Average Number of Clients in Group:	N/A	N/A	N/A	
Average Number of Staff in Group:	N/A	N/A	N/A	

4. Occupancy Space Utilization

TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE			
Square Ft.Used	Occupancy Total Exp.	Square Ft.Used	Allocated Expense	Allocated Expense %	Allocated Expense Dollars	Allocated Expense %	Allocated Expense Dollars	Allocated Expense %	Allocated Expense Dollars	Allocated Expense %	Allocated Expense Dollars
			0	0.0	0	0.0	0	0.0	0	0.0	0

5. SERVICE UTILIZATION AND REVENUE BY PAYER SOURCE

	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE			
	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS
Massheath Only (non-MCE)	559.73	266,148			219.75	97,580	339.97	168,569				
Massheath MCE MBHP	7,397.21	684,377			481.96	208,146	586.30	300,716	6,328.96	175,515		
Massheath MCE Fallon	0.00	0			0.00	0	0.00	0				
Massheath MCE NHP	703.78	65,410			77.94	23,903	94.81	27,990	531.03	13,517		
Massheath MCE Tufts-Network Health	441.44	80,502			106.26	36,371	129.27	38,720	205.91	5,411		
Massheath MCE BMC Health Net	2,547.96	212,631			235.23	74,512	286.16	82,745	2,026.57	55,375		
Massheath MCE HNE	32.51	720			0.00	0	0.00	0	32.51	720		
DMH Only	0.00	0			0.00	0	0.00	0				
Medicare/Medicaid	848.26	392,661			451.78	202,578	396.48	190,082				
Medicare Only	0.00	0			0.00	0	0.00	0				
Uninsured	315.88	90,827			83.84	35,725	101.99	51,714	130.05	3,388		
Commonwealth Care Fallon	0.00	0			0.00	0	0.00	0				
Commonwealth Care NHP	0.00	0			0.00	0	0.00	0				
Commonwealth Care Tufts-Network Health	0.00	0			0.00	0	0.00	0				
Commonwealth Care BMC Health Net	0.00	0			0.00	0	0.00	0				
Commonwealth Care Celticare/Cenpatico	0.00	0			0.00	0	0.00	0				
Health Safety Net	35.32	16,621			15.94	6,791	19.39	9,830				
Care Plus BMC	503.42	152,794			227.12	73,118	276.29	79,676				
Care Plus Fallon	1.97	558			0.89	312	1.08	246				
Care Plus NHP	143.18	44,728			64.60	22,022	78.58	22,706				
Care Plus HNE	21.72	7,602			9.80	3,430	11.92	4,172				
Care Plus Celticare	111.84	22,091			31.79	10,699	80.05	11,392				
Care Plus Tufts-Network Health	175.65	56,000			79.25	27,124	96.40	28,876				
One Care CommCare Alliance	196.09	98,248			70.83	34,871	125.25	63,377				
One Care Fallon	0.00	0			0.00	0	0.00	0				
One Care Tufts-Network Health	17.30	5,515			7.80	2,671	9.49	2,844				
Commercial Insurer	0.00	0			0.00	0	0.00	0				
Commercial with MH TPL	0.00	0			0.00	0	0.00	0				
Other	0.00	35,476		35,476	0.00	0	0.00	0				
Total Service Utilization/Revenue	14,053.26	2,232,908	0.00	35,476	2,164.79	859,852	2,633.45	1,083,656	9,255.02	253,925	0.00	0

Note: CCS: 1 unit = 1 bed day; Adult Mobile: 1 unit = 1 encounter; Child Mobile: 1 encounter = 10 units

Appendix X: Organizational Commitments Pursuant to Massachusetts Privatization Law

Under Massachusetts' Privatization Law (M.G.L. c. 7 §§ 52, 53, 54, and 55), a successful bidder must:

(i) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:

1. provided ESP services; and
2. were terminated as a result of DMH ceasing to provide such ESP services;

(ii) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees; the Commonwealth currently contributes 80% of the cost of health insurance DMH employees.

(iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate as determined by the state pursuant to M.G.L. c. 7 §54 (2) for those positions for which the duties are substantially similar to the duties performed by regular agency employees;

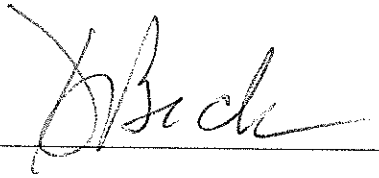
(iv) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons; and

(v) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

In addition, a successful bidder must certify in writing to the state that both the organization and its supervisory employees, while in the employ of the successful bidder, have "no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest."

Name of Organization: Boston Medical Center

I hereby acknowledge that if the organization listed above is chosen to provide ESP services in the Southeast region of Massachusetts, the organization must implement the relevant provisions of the state's Privatization Law referenced above.

Signature: 

Name and Title (please type or print): David Beck, Vice President & General Counsel & Clerk

Date: September 3, 2015

Letters of Support

Justice Resource Institute

August 11, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

Justice Resource Institute (JRI) is pleased to support the proposal of Boston Medical Center Psychiatry, with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

JRI has multiple residential and community-based services throughout the Southeastern region of Massachusetts. These include adolescent therapeutic residential schools (Swansea Wood School & Meadowridge Academy), outpatient clinics in Taunton and Attleboro, a STARR program, the Lindencroft group home for girls, a CBAT, the DCF/DMH Caring Together Continuum, and the Cape and Islands CSA (the CBHI network) that provides extensive community-based services serving hundreds of families. We have worked for many years with the DMH ESPs in the area, and have developed strong relationships with them.

The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC proposes the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center
- 24/7 access to board-certified BMC adult and child psychiatrists
- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth

- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Southeast Region.

Sincerely,

Andy Pond, LICSW
President and CEO

Get Connected GW Stay Connected

GROWTHWAYS, INC.
Community Supports for People with Developmental Disabilities
41 North Pearl Street, Brockton, MA 02301 (508) 941-6505 fax 583-7651

August 19, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802

Dear Dr. Buczek:

Growthways, Inc. is pleased to support the proposal of Boston Medical Center Psychiatry, along with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

Growthways, Inc. is a non-profit organization that provides education, training, advocacy, and support services to people with intellectual/developmental disabilities and their families in the Greater Brockton Area. We provide a variety of services which include: residential and independent living programs as well as placement services. We currently provide residential services to 80 individuals. Our organization is dedicated to providing quality services where individuals are supported and empowered to be valued, contributing members of their community.

We are familiar with the programs operated by the team submitting this proposal. The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs, while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC is proposing the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center

- 24/7 access to board-certified BMC adult and child psychiatrists

- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth
- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Greater Brockton Area.

Sincerely,

Marty Berliner
President & CEO

The Arc
Bristol County

141 Park Street
Attleboro, MA 02703
t 508 226-1445
f 508 226-1476
www.arcnbc.org

August 19, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

The Arc of Bristol County, Inc. is pleased to support the proposal of Boston Medical Center Psychiatry, with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

The Arc of Bristol County began in 1959 as a grassroots organization of parents whose children had mental retardation. Families who once believed they were alone found support and fellowship among other families facing the same challenges. It is an organization with a track record of 52 years, helping people with intellectual and developmental disabilities to gain many of the rights afforded by citizenship. They work, they own homes, and they contribute to the rich diversity of their community. The Arc's advocacy, research, programming and outreach have played a pivotal role in these advances. Today, The Arc of Bristol County provides a wide array of supportive services to over 2,000 children and adults with intellectual and developmental disabilities, and their families, helping them to maximize their talents and abilities, develop independent living skills, and participate as contributing citizens of their communities.

The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC proposes the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center

- 24/7 access to board-certified BMC adult and child psychiatrists
- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth
- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Southeast Region.

Sincerely,

Michael Andrade
President and CEO

NAMI
National Alliance on Mental Illness
Massachusetts

September 9, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

On behalf of NAMI Massachusetts, I am pleased to write this letter offering my strong support of your proposal to provide emergency services in four catchment areas in the Southeast Region of Boston.

NAMI Mass is a nonprofit agency dedicated to supporting both people with mental illnesses and their families. As Executive Director, I am well aware of our longstanding affiliation with BMC. We have partnered together on many initiatives, including the Boston Emergency Services Program, the Cambridge/Somerville Emergency Services Program, the Metro Boston Recovery Learning Community and the Southeast Recovery Learning Community Program. For the current proposal, I understand that you hope to include NAMI Mass members on your advisory committees, as well as work with them directly to provide crisis services to families and individuals in the Southeast area. I believe that our organization is well positioned to assist in these roles; our membership is comprised of individuals living with mental illness, their families and friends, mental health professionals and others who care about people with mental illness.

I am very pleased to lend our organization's support to this project, and look forward to collaborating with BMC on yet another important initiative. I wish you the best of luck during the review process.

Sincerely,

Laurie Martinelli
Executive Director

The National Alliance on Mental Illness of Massachusetts
The Schrafft's Center • 529 Main Street • Suite 1M17 • Boston, MA 02129-1125
P: 617.580.8541 F: 617.580.8673 Toll free: 800.370.9085 E-mail: info@namimass.org W: www.namimass.org

the TRANSFORMATION center

August 31, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center
85 E. Newton Street, Room 802
Boston, MA 02118

Dear Dr. Buczek:

On behalf of the Transformation Center, I support your bid(s) to lead the Cape and the Islands, Taunton/Attleboro, Fall River, and Brockton Emergency Services Program(s).

As you know, The Transformation Center is one of the first mental health and trauma recovery-oriented organizations in Massachusetts and is recognized as a national leader in trauma informed peer support and training. Our organizational mission is that people –with all our vulnerabilities and strengths, live in communities where people help each other with mutual respect and compassion to overcome the challenges in life. We promote the growth and voices of people with lived experience of mental health, substance use and trauma so that they may find their unique paths to healing and recovery, and so that they may impact and transform policy and practice.

Your proposed emergency services program(s) will meet critical service needs for members of the Cape and the Islands, Taunton/Attleboro, Fall River, and Brockton communities. The mobile crisis intervention and community crisis stabilization services that you propose are integral in supporting the recovery of children, families and adults. We are particularly pleased that there will be significant involvement of peer specialists in your Emergency Service Programs.

Please let me know if there is anything else we can do in support of your bids.

Sincerely,

Deborah Delman
Executive Director

Phone: (617) 442-4111
Toll free: (877) 769-7693
VP: (617) 606-7512
FAX: (617) 442-4005

100 Magazine Street
Roxbury, MA 02119
Website: www.transformation-center.org
Email: info@transformation-center.org

Compassion Counseling Services, PC

First, we listen...

488 West Center Street Suite #2
West Bridgewater, MA 02379
Phone: (508)297-0015
Fax: (508)297-1821
www.compassioncounselingservices.com

8/13/15

RE: Letter of support

To Whom It May Concern:

I am writing on behalf Compassion Counseling Services, PC in support of Boston Medical Center Psychiatry, with partners Bay Cove Human Services and Vinfen's proposal for the four Southeast region emergency service program contracts up for bid. I have direct experience working for and with the BayCove UCC/Mobile Crisis Team. I can't imagine a more competent group of experienced and clinically sound professionals taking on these contracts. They continue to bring consistent, high quality, community-based crisis services to the diverse populations in the areas they serve. I have no question they are the best candidate for the job and will be able to effectively use their model to meet the needs of the community and save lives of the individuals in the most need of services. If you have any questions or concerns, you can contact me at (508)297-0015 ext 2

Sincerely,

Erin Bell, LMHC
Psychotherapist/Owner

Massachusetts Behavioral Health Partnership (MBHP)
Emergency Services Program (ESP) RFR

APPENDIX VII: RESPONSE COVER SHEET

Organization name: Community Counseling of Bristol County, Inc.

Proposed catchment area name: *Please submit individual proposals pertaining to each catchment area for which your agency is submitting a response:*

☒ Brockton ☐ Cape and Islands ☐ Fall River ☐ Taunton/Attleboro

Contact person: Philip Shea **Title:** President/CEO

Mailing address: One Washington Street
Taunton, MA 02780

Telephone number: 508-977-8100 **Fax number:** 508-824-6604

E-mail address: Philip.shea@comcounseling.org

Proposed subcontractor(s), if any: *(Please repeat this section if proposing more than one.)*

Organization name: _____

Contact person: _____ **Title:** _____

Mailing address: _____
_____
_____

Telephone number: ____-_____-_____ **Fax number:** ____-_____-_____

E-mail address: _____

Service component(s) for which the bidder proposes to subcontract to the above:
___ Child Mobile Crisis Intervention
___ Adult Mobile Crisis Intervention
___ Community-based location
___ Adult Community Crisis Stabilization (CCS)
___ Other: (specify) _____

This cover sheet must be the first page of the bidder's response.

380320.1

1. General qualifications and infrastructure:

1.1 Licensure:

1.1.1 Licensed as an outpatient mental health clinic by the Department of Public Health (DPH) ☒ Yes ☐ No

1.1.2 Licensed as a hospital

1.1.2.1 by the DPH ☐Yes ☒ No

1.1.2.2 by the Department of Mental Health (DMH)☐ Yes ☒ No

1.2 Accreditation:

1.2.1 Accredited by a national organization ☐Yes ☒ No

1.2.2 If yes, please list accreditation(s).N/A

1.3 Currently contracted MassHealth provider or application in process: ☒ Yes ☐ No

1.4 At least three years' experience providing behavioral health services to a wide range of populations: ☒Yes ☐ No

1.4.1 Number of years providing behavioral health services to children, adolescents, and families: 45

1.4.1.1 Number of youth served in CY14: 3,000

1.4.2 Number of years providing behavioral health services to adults: 45

1.4.2.1 Number of adults served in CY14: 9,000

1.4.3 Briefly describe the behavioral health services your organization has provided and the populations to which your organization has provided these services.

Community Counseling of Bristol County (CCBC) is one of the largest community-based behavioral health providers in Southeastern Massachusetts and has been operating for over 45 years. CCBC has transformed itself from a traditional outpatient behavioral health provider delivering office-based treatment created from a medical-model to a strength-based recovery-oriented provider with a broad continuum of services for children, their families, adults, and elders.

Today CCBC serves over 12,000 clients each year, from children with serious emotional disturbance (SED) and their families, adults with serious and persistent mental illness (SPMI), to frail elders. In addition to office-based treatment, clients also receive services in their homes, schools, health centers, and other community settings. CCBC has also become the leader in developing peer supports for adults and for parents with a child with serious emotional disturbance. The agency employs 14 peer specialists, most of whom are "certified peer specialists" and 10 family partners. CCBC serves persons with serious and persistent mental illnesses in their outpatient clinics and under contract with the Department of Mental Health (DMH) for their Community-Based Flexible Supports (CBFS) and Program for Assertive Community Treatment (PACT) Programs. Both CBFS and PACT programs have developed strong collaborative relationships with local housing authorities and federal Department of Housing and Urban Development (HUD) to expand the supply of safe, stable, and affordable housing that is needed to support recovery. Additionally, the agency serves children with serious emotional disturbance with a full continuum of services under the Children's Behavioral Health Initiative (CBHI) and in our outpatient clinics.

Over the last twenty years CCBC has provided the 24-hour emergency psychiatric coverage to the Taunton/Attleboro Emergency Services Program operated by the DMH. For the past twelve years CCBC has provided this psychiatric coverage to the Brockton Emergency Services Program. CCBC also leases space and provides operational support for the Taunton/Attleboro Community Crisis Stabilization Program in Norton. Since 2013, CCBC has provided mobile crisis intervention services (MCI) to the DMH Emergency Services Programs (ESPs) in Brockton and Taunton.

1.5 Presence in and knowledge of the catchment area for which your organization is applying for an ESP contract.

CCBC has operated programs serving residents of the Brockton catchment area for over 15 years through the operation of three community-based programs: 1) The Community Support Program (CSP) for 15 years; 2) PACT for eight years; and 3) ESP Psychiatry for twelve years. Additionally, CCBC has provided MCI services for two years. The staff in all of these programs have developed working relationships with DMH case managers, local outpatient providers, hospital inpatient units, hospital emergency department staff at both Brockton and Good Samaritan Hospitals, and the current Emergency Services Program operated by DMH.

From their experience, CCBC has learned that there are many challenges in Brockton. The CCBC-contracted psychiatrists who have been part of the DMH ESP have also developed a great deal of knowledge about the catchment area. Brockton demographics represent an increasingly diverse population with significant populations of Latinos and Cape Verdeans, alongside poor and working class Whites in a struggling local economy.

1.5.1

1.5.1.1 CCBC's CSP program has been operating in Brockton for 15 years. The psychiatrists serving the ESPs have been housed at the Brockton Multi-Service Center (BMSC) for ten years. The Brockton PACT program has been operating for eight years.

1.5.1.2 The CCBC PACT and CSP programs have been operating at 4 Main Street since 2006 and recently moved to 56 Cherry Street in Brockton.

1.5.1.3 CCBC has already begun to identify available space in the Brockton catchment area to establish the Community-Based Location (CBL) and the Community Crisis Stabilization program (CCS). We have found suitable space at 157 Main Street, Brockton, the former location of the Brockton Neighborhood Health Center. Upon award of the contract, CCBC will begin negotiations to secure a lease for both CBL and CCS space at this address. The negotiations will include a build-out to establish a six-bed CCS and CBL. The space is already handicapped accessible. The CCS design will parallel the model for the Taunton/Attleboro design, with the exception of one less bed. We will negotiate to have the build-out completed within three months of the contract award for the Brockton ESP program.

CCBC seeks to offer the Brockton area an expanded continuum for the services already being provided. The PACT program and the CSP program serve some of the highest risk clients in the area. The ESP will expand the capacity to coordinate care and build on CCBC's strong reputation as a consensus builder among community agencies to provide greater opportunities for recovery for children, adolescents and adults facing psychiatric crises.

1.5.2 The Brockton catchment area has a full continuum of 24-hour and community-based diversionary behavioral health services, including: an inpatient psychiatric unit at Brockton Hospital; Detoxification services at High Point Brockton; and Community-Based Acute Treatment (CBAT) services through the McLean Hospital Brockton CBAT. Other services

include the DMH-operated Community Crisis Stabilization program, the CSP program operated by CCBC, the Brockton PACT operated by CCBC, the Brockton CBFS programs operated by DMH and BAMSI, and the full continuum of CBHI services operated by BAMSI. Brockton also has a high concentration of residential programs funded by state agencies: The Brockton YMCA has a boys and girls detention unit; DCF operates the Transitions Program for transitional-aged youth; and DPH funds the Castle Program, a residential program for adolescent substance abusers. The high concentration of these residential programs adds to the population of at-risk youth in the Brockton catchment area.

Brockton is one of the largest and most diverse cities in Massachusetts, with high concentrations of African-Americans, including Angolan refugees, Cape Verdeans and Latinos. There is a high rate of violence and poverty that puts additional stresses on limited city resources and adds to the roles of local social services, including behavioral health services and emergency room services.

The crisis continuum has several strengths including a well-known physical location at BMSC that has been in place for more than 20 years. Another strength is that the ESP is centrally located on property adjacent to Brockton Hospital. This physical location includes the 6-bed Community Crisis Stabilization program and Case Management offices of DMH, and DMH area office staff. In addition, all local behavioral health providers, law enforcement, and many community service providers are already familiar with BMSC.

The limitations of the crisis continuum include the capacity of the ESP staff to conduct mobile visits for both children and adults in psychiatric crisis beyond the Brockton Hospital and Good Samaritan Emergency Departments.

Another barrier in the current system is the difficulty in information exchange. For example, the current ESP solicits crisis plans and safety plans from community providers but does not have the capacity to integrate those plans into their electronic medical records (EMR) system or retrieve them or other data from the EMR from remote locations. There are also delays in communicating information to ESP clinicians in the field about a member's prior history with the ESP. When community CBFS, CSP, and PACT providers develop a crisis plan for a member at risk, the paper document is rarely accessed by the ESP staff.

Finally, there is the limitation in the capacity of the ESP to reduce the back up in the Brockton Hospital ED during periods when there is high ED volume.

1.5.3 CCBC's CSP staff has developed strong working relationships with the full range of behavioral health and community resources in Brockton, including outpatient clinics, law enforcement, community health center, and social service agencies. This established credibility will allow CCBC to quickly pivot those relationships into an effective and responsive ESP; especially with the local hospital ED's and community service programs that often refer persons for crisis intervention.

Another strength is that the CCBC psychiatry program is currently contracted with the DMH ESP in Brockton. The CCBC-contracted psychiatrists will provide clinical continuity for that component of the ESP into the implementation of the CCBC ESP in Brockton.

The CCBC PACT in Brockton is another program that has established relationships with stakeholders in Brockton that include homeless shelters, Brockton Neighborhood Health Center, Signature Healthcare, and local law enforcement.

1.5.4 CCBC holds the contract with DMH for psychiatric services in the DMH ESP that is currently operating. The psychiatrists have a key role in diverting clients from inpatient care

into the CCS program or back to their CBFS, PACT, or outpatient providers when the psychiatric emergency can be stabilized by ESP staff.

CCBC also holds a contract with DMH to provide MCI services that add capacity to the existing ESP. These staff are adept at working on a mobile basis through the Brockton catchment area, stabilizing family crises and providing follow-up visits in the home to maintain stability and extend community tenure during the course of a seven-day intervention and beyond.

The CCBC CSP program staff interfaces with a host of community providers and are very knowledgeable about the clinical baseline of persons with SPMI. CSP staff are skilled at working with outpatient providers, community health centers, and landlords to provide support that minimizes the current psychiatric episode, addresses the client's clinical triggers and provides additional support to maintain the member's stability.

The CCBC Brockton PACT is well-trained to work with the 80 clients in a community setting to provide additional resources in a psychiatric crisis and minimize referrals to the hospital ED and ESP for evaluation. CCBC is also the contractor in the Southeast area for the Runaway Assistance Program (RAP).

1.6 Continuum of care

CCBC has evolved as an organization into a provider that has internalized a strength-based, recovery-oriented approach to the treatment of mental illness and addiction. CCBC management and clinical leadership have ensured that this approach is applied comprehensively and uniquely in each of the programs it operates: The Community Support Program has developed *"retail"* relationships with behavioral health and medical providers, including nurses in local emergency rooms. The ongoing collaboration has evolved into a credible relationship to make a case for diversions and community-based alternatives. CCBC's Community-Based Flexible Supports (CBFS) builds a full program around persons with SPMI that includes housing, daily supports, clinical treatment and coordination with primary care providers to prevent support recovery, manage co-morbid health conditions, and addresses any potential triggers to psychiatric crises that the clients identify. CCBC's Community Service Agency (CSA) has built a culture that is a family-focused and strength-based approach to strengthen the coping skills of families and their children to address crises in the home.

The psychiatrists assigned to the current DMH ESP Contract have developed a body of experience to support increased diversion and client stabilization for community providers and ESP clinicians to address and stabilize psychiatric crises.

In the MCI program, CCBC has a group of clinicians already providing MCI services within the DMH program. CCBC will provide additional value for the Children's system in operating the MCI by bringing its skills and experience in collaboration with the Brockton Systems of Care and actively participating with the other stakeholders to promote *"family voice and choice"* and a strength-based approach to resolving psychiatric crises for children with SED and their families.

1.7 Administrative infrastructure

CCBC's organizational structure includes the following positions that will provide the administrative and fiscal oversight and management of the ESP contract: President/CEO; Chief Operating Officer; Medical Director; Chief Financial Officer; Director of Children's Services; Community Service Agency Director; Quality Management Director; and Information Technology Support

1.8 Medical and clinical infrastructure:

The medical and clinical oversight and management will be the responsibility of the Chief Operating Officer; Medical Director; Emergency Services Program Director;

1.9 Quality Management (QM) infrastructure

1.9.1 Identify key staff positions and other infrastructure elements that will enable your organization to provide quality management and risk management of an ESP contract and service delivery system. The Quality Management Director, and Utilization and Outcome Analyst will be responsible for the quality management and risk management elements of this contract.

1.9.2 Required attachment: your organization's current Quality Management plan ***See Attachment 1.9.2***

1.9.3 Quality Management and Performance Outcomes: At CCBC, Quality Management is first and foremost defined by an organizational commitment to quality care and to a continuing process for improving that care. Supporting this commitment are organizational structures and processes designed to measure, monitor, and evaluate the care provided to clients in order to improve care. The components of this plan ensure the successful implementation of new services, such as the Brockton Emergency Services Program (ESP), as well as the ongoing operations of existing programs. Major components of this plan include:

- Risk Management Committee
- Utilization Management Plan
- Performance Improvement Committee
- Professional Services Review Committee
- Human Resources Management Committee
- Patient Care Assessment Committee

Upon a contract award, CCBC will develop a comprehensive evaluation plan for the Brockton ESP which will include:

- Development of specific tools to measure the Performance Indicators in the RFR;
- Establishment of specific performance targets utilizing a HIPAA compliant EMR; and
- Establishment of a data set to submit to CCBC Executive Management on a monthly basis.

1.9.4 Provide specific examples how you shall use data and information, such as those identified in Section C.4 and C.5 below, to ensure and continuously improve the quality of ESP services and the performance of the ESP contract.

CCBC has established a series of *"Dashboard"* reports that will be adapted for the ESP in Brockton to measure volume of activity. These reports will be updated to stratify crisis interventions by location: Community-Based Mobile Crisis Intervention, such as school, home, or CBFS program site; ESP-Community-Based Location, or Hospital ED. The volume will be tracked against the Performance Indicators in the RFR.

The Quality Management (QM) Director and staff will calculate compliance from the times marked on the ESP intake form with the 60-minute response time for face-to-face contact with the client requesting crisis intervention. Prior reviews of the data have led to improvements in staffing to reduce the response time.

The QM Director has access to a number of statistical programs to evaluate the data that is collected on outcomes, service delivery, and satisfaction. These include SPSS and SASS.

2. *ESP Core Competencies*

2.1 Crisis services

2.1.1 CCBC has provided the coverage for Emergency Psychiatric Services to the current DMH ESP programs in Brockton since 2003 and in the Taunton/Attleboro area since 1993. The psychiatrists are Board Certified in Psychiatry by the American Board of Psychiatry and Neurology, have been credentialed and privileged by DMH, and meet MBHP's credentialing criteria. In their role they have developed competencies in crisis assessment, risk management, safety planning, and in effecting timely placements for complex clinical presentations. Their scope of duties includes medical oversight of clinical evaluations by ESP clinicians and clinical management of the Community Crisis Stabilization (CCS) programs in the Brockton and Taunton/Attleboro catchment areas. Under this contract CCBC also leases the property in Norton where the ESP is located.

Since 2013, CCBC has also provided the DMH ESP's in Brockton and Taunton/Attleboro with Mobile Crisis Intervention (MCI) services on a contracted basis.

2.1.2 CCBC's psychiatric staff have responded to 24/7/365 requirements of the ESP for more than 20 years. The MCI contracted staff responds to requests for mobile visits within the 60-minute standard established for ESP programs. CCBC's In-Home Therapy staff has been trained to be flexible in addressing a family's changing needs, including increasing the timely response when the family is in crisis or at risk. CCBC operates many programs that require and receive a rapid response on a 24-hour basis, including: Community-Based Flexible Support (CBFS) Services; Program of Assertive Community Treatment (PACT); Community Support Program (CSP); Intensive Care Coordination (ICC); and In-Home Therapy (IHT).

2.1.2.1 **Experience**. The MCI staff under contract to DMH have been able to respond to requests for mobile visits within the required timeframe since the services were added to the contract. CCBC's clinical managers have provided clinical and administrative back-up for all of CCBC's adult and children's programs, with established protocols and support for staff to meet client needs and contractor requirements.

Specific Strategies to Meet Response Time. First, CCBC will have a "*Central Telephone Triage Center*" to deploy clinicians from the Brockton ESP to meet the one-hour response time, with back-up from relief staff in Brockton and relief staff in the proposed Taunton/Attleboro ESP. CCBC will use several additional strategies to meet the standard of a one-hour response time: 1) Posting clinicians at the Good Samaritan and Brockton Hospital Emergency Departments during later afternoons and evenings, historically periods of high demand; 2) mobilizing additional mobile clinicians to provide back-up to these assigned clinicians when unusual demand spikes in the EDs;3) expanding the pool of available back up ESP staff in Brockton with on-call staff available from the Taunton/Attleboro ESP should CCBC be awarded both contracts; and 4) through recruitment of additional on-call clinicians from CCBC's roster of licensed clinicians.

2.1.2.2 Within its current Emergency Psychiatry contract with DMH, CCBC provides 24/7/365 psychiatric back-up with consistent 15 minute or less telephone responsiveness and meets all response requirements for MCI back-up to DMH. CCBC has a lengthy track record of managing these resources. The reports that CCBC submits to DMH indicate full compliance with the timeliness and other key contractual requirements.

Strategies. CCBC's Brockton ESP will strengthen the capacity to address the fluctuating demand by creating a position called *"hybrid"* clinician. This will be a CCBC salaried employee with access to full employee benefits. They will be hired at a reduced salary and receive

additional fees for providing mobile ESP crisis interventions across the Brockton and Taunton/Attleboro catchment areas, should CCBC be awarded both contracts.

CCBC will also develop a *"Central Triage* "to coordinate the efficient and timely use of clinical resources in the Brockton and Taunton/Attleboro areas. Staff will be deployed in real time to where they are needed when fluctuations in demand require additional resources. An example of another strategy by CCBC to monitor timely access based on fluctuating demand will be the establishment of a "*Dashboard.*" The Dashboard will report data gathered from its ESP Electronic Health Record to review timely responses on a daily basis to ensure that all timeliness standards are being met. The chief operating officer, medical director and ESP program director will meet weekly to review responsiveness, identify barriers to access, and implement corrective actions as needed.

2.1.2.3 **Hiring Experience**. Throughout the more than 20 years of the contract with the DMH-operated ESP, CCBC has been successful in recruitment, hiring, and retention of the psychiatrists for the Emergency Psychiatric Services in the DMH programs in both Taunton/Attleboro and Brockton. CCBC has also had success in recruiting and retaining qualified staff for the MCI contracted program. CCBC's Human Resources Department recruits a range of staff for CCBC's other programs, many of which operate outside of the 9-5, Monday-Friday schedule.

Strategies to hire ESP Staff.

1. If awarded the contract, the executive staff at CCBC will outreach the existing staff of the Brockton ESP to offer qualified staff positions for the CCBC program.
2. If awarded the contract, CCBC would recruit candidates for ESP both internally posting ESP positions and externally through advertising and the engagement of a recruiting firm.
3. Through a contract with a national training organization, CCBC maintains a catalog of over six hundred online courses relevant to the needs of behavioral health care organizations. CCBC will add key training curricula on providing recovery-based crisis interventions for the ESP clinician and MCI clinician to be completed prior to their deployment.
4. Orientation and on-the-job mentoring to build skills in crisis intervention. As part of the orientation to ESP, the new hires will shadow an experienced ESP clinician during the course of crisis intervention on eight separate cases. Before each new clinician is allowed to make independent clinical decisions, they must pass an ESP clinician *"Competency Test"* on ESP capabilities.

2.2 Mobile services

2.2.1 CCBC has provided mobile services in Brockton through their CSP Program for 15 years and their PACT program for eight years. The CSP serves over 500 clients per year in Brockton. These clients are MassHealth members at risk of psychiatric hospitalization or who typically have been recently discharged from 24-hour care. CSP case managers spend 90% of their working hours in community settings with these clients and work with them to prevent the need to utilize the ED and more restrictive 24-hour services. The CSP conducts these activities as mobile interventions throughout the Taunton/Attleboro or Brockton catchment area.

The Brockton and Taunton/Attleboro PACT programs serve DMH clients with serious and persistent mental illness in community settings. The PACT program is a mobile team that sees the clients in many different community settings, essentially bringing clinical staff – from peer support to psychiatrist – to the client. Based on DMH program evaluations, the CCBC PACT team meets the DMH standard of 90% client interactions occurring in a community setting.

The CCBC continuum of Children's Behavioral Health Initiative (CBHI) services: Intensive Care Coordination, Family Support, In-Home Therapy, and Therapeutic Mentoring are all provided on a mobile basis to children with serious emotional disturbance (SED) and their families. CCBC has been operating CBHI services for six years.

2.2.2 CCBC's orientation towards recovery in both adult and children's programs includes a foundation that most, if not all, services can be provided safely in the community. CCBC's wide variety of interventions – CSP, PACT, and MCI staff in Brockton – and CSP, CBFS, PACT, CBHI, and Outpatient services in the Taunton/Attleboro area have resulted in a culture of community-based support for adults with SPMI and children with SED that promote client empowerment, a strength-based approach to the member, and partnership in developing a wide range of solution-focused interventions.

Strategies. Based on this foundation, CCBC will orient the ESP staff to the effectiveness of mobile services in promoting recovery and resiliency. The ESP program director will gather examples of mobile interventions to demonstrate how mobile services can be effective as a crisis prevention and intervention tool. The menu of case examples will be expanded as the ESP staff builds their own body of work through mobile outreach and intervention.

CCBC ESP staff will participate actively in the *"Citizen X"* community meeting that already involves CCBC's Brockton PACT and CSP staff. This forum in Brockton involves local behavioral health providers, Brockton police, representatives from the hospital emergency departments, and Brockton Neighborhood Health Center. The purpose of the meeting is to develop community-based preventive strategies to divert high-risk members from the Emergency Room as an overall part of the 10-Year Plan to End Homelessness in Brockton.

As high volume referral sources are identified, the ESP program director will designate ESP staff as liaisons to these stakeholders, which may include group living environments, nursing homes, or local police. These *"ambassadors"* will personally carry the message of the belief in community mobile intervention.

2.2.3 CCBC has conducted a preliminary assessment of the challenges in establishing a culture and practice of prioritizing mobile services listed below:

- The DMH-operated ESP does not prioritize mobile visits.
- Community stakeholders have limited experience with mobile ESP services.
- CCBC's CSP and PACT staff work in many areas of Brockton and are aware of the potential risk, that have been addressed in CCBC's Safety Committee, including the potential for physical harm or criminal victimhood in a few Brockton neighborhoods. Mobile ESP and MCI services can also pose a risk of exposure to physical harm or crime in a few Brockton neighborhoods. To address and mitigate the challenges above, CCBC proposes the following strategies:
- CCBC will establish a Community-Based Location(CBL) in Brockton that is co-located with the Brockton CCS program;
- CCBC will develop a social marketing campaign to educate the community stakeholders about the mobile capacity of the ESP in the Brockton area;
- CCBC staff will establish orientation programs to the Brockton area neighborhoods and surrounding towns for ESP staff;
- ESP staff will conduct introductory meetings with DMH and BAMSI CBFS providers, Caring Together Providers, DYS residential programs at the Brockton YMCA, homeless shelters, schools, and community health centers to build initial working relationships between ESP and sources of referrals for mobile visits;

- CCBC will engage the members of the Brockton Police Department who have participated in the Community Crisis Intervention Team (CCIT) program, to help as ambassadors to other law enforcement staff in the Brockton area in establishing a culture and practice for mobile services;
- CCBC will strengthen the *"Citizen X"* forum and provide working examples of successful mobile visits.

2.2.4 CCBC is the CSA provider in the Taunton/Attleboro area. They have established the full continuum of CBHI services and a number of working collaborations with community stakeholders, including the DMH MCI program. The hiring, orientation, and ongoing support for staff includes providing comprehensive training, supervision, and ad hoc consultation for family partners and clinicians. CCBC has also developed a continuum of care with the DMH MCI program to support families in crisis during the seven-day crisis episode and also ensuring continuity of care with ICC and IHT services that will provide continued intervention for the family.

2.3 Diversion

2.3.1 ED diversion

2.3.1.1 CCBC's clinical leadership that includes the medical director of the psychiatric services for the Brockton and Taunton/Attleboro ESP's, has a broad range of experience in assessing clinical risk for clients, both in the ESP setting and in our community programs that include PACT, CBFS, CBHI services, and CSP. Similarly the CCBC Child MCI Team that are part of the existing DMH ESP have two years of experience providing community-based diversion as an alternative to hospital level of care.

We have worked collaboratively with clients to develop individual safety plans that establish a clear set of supports for care that can be delivered in the community as an upstream intervention prior to going to the ED or inpatient hospitalization. These safety plans incorporate client strengths, preferences, and natural supports that result in a consumer-directed plan. For families participating in the CBHI services, clinicians and family partners work with families and their children to develop a risk and safety plan to support families when the child is in a crisis based on the child and family's strengths and preferences.

2.3.1.2 CCBC can bring several important community resources to the Brockton catchment area to create and strengthen a culture of providing crisis services outside of the hospital ED. First, CCBC's ESP staff will convene community stakeholders to reinforce their experience in working with high risk clients in community settings and emphasize the added value of the ESP to support these stakeholders. Second, the CCBC MCI staff will participate in the Brockton CSA Systems of Care meetings and share the capacity and competence of the MCI staff, as well as provide working examples of how children and families can be served in community settings by activating the Safety Plans. Finally, CCBC will build on the CCIT training already provided to law enforcement officials in Brockton to expand the visibility of the ESP and the CCIT skills to a larger law enforcement and human services audience.

The Brockton ESP will also develop the culture through rigorous data collection that aggregates the percentage of mobile visits versus ED visits and profiles ED visits that could have been seen in community settings. These data will provide concrete evidence to the stakeholders – ED staff, parents, referral sources, and ESP staff –of the merits and effectiveness of ESP evaluations outside of the ED.

Ultimately, CCBC will establish a Community-Based Location that is accessible and welcoming and will be attractive to clients and stakeholders alike.

2.3.1.3 As part of the strategy to change the perception that all or most psychiatric crises must be sent to the local hospital ED, CCBC will familiarize key stakeholders with the value and utility of the Community Crisis Stabilization (CCS) programs, the Community-Based Location in Brockton, and the mobile crisis intervention capacity for adults and children that can provide ongoing support for up to seven days as part of the Mobile Crisis Intervention. The targeted populations include clients served by the local offices of DMH and DCF, persons referred by local police, other mental health and substance abuse providers, and persons referred through local advocacy organizations such as PAL and NAMI-Mass, and consumer groups. Specific points to be emphasized in this targeted outreach will include:

- Increase awareness of the mobile capacity of the ESP;
- The capacity of the CCS to provide a staff-secure setting that resembles an inpatient psychiatric unit in several ways;
- CCBC will address the law enforcement community by expanding the CCIT training to a larger audience of police officers in the Brockton catchment area. This model has been very successful in Taunton.

2.3.1.4 CCBC is aware of a number of challenges to the pattern of reliance on Hospital Emergency Departments for behavioral health emergencies:

- CCBC will have to forge expanded relationships with the two hospitals in the Brockton Area – Good Samaritan Hospital and Brockton Hospital – at the administrative, clinical and programmatic level;
- The recent history of periods of high volume of mental health clients waiting in the Emergency Room for inpatient placement;
- The community stakeholders have only limited experience with mobile ESP visits from the DMH-operated teams;
- Mobile ESP and MCI services pose a risk of physical harm or criminal victimhood in some Brockton neighborhoods.

Strategies. With the social marketing campaign, CCBC will expand on the established relationships developed by the CCBC PACT and CSP programs with other community-based behavioral health providers and hospital systems, including their Emergency Departments. CCBC also has experience working with hospitals in preventing reliance on the ED for crisis interventions:

- CCBC's ESP medical director will reach out to the ED medical directors at Brockton and Good Samaritan Hospitals to encourage their active participation in these forums to demonstrate the success of mobile visits and a willingness to set up a continuous quality improvement climate;
- The working relationship with the DMH Brockton area will provide a platform to work with the two hospitals and build trust and credibility.
- CCBC will eliminate the requirement for medical clearance for admission to the CCS, providing the admission is reviewed by a CCBC physician.

CCBC will work with MBHP and local outpatient providers to improve access to Urgent Care appointments as a timely resource for persons evaluated by the ESP and needing immediate outpatient follow-up.

2.3.2 ED-specific plans

2.3.2.1 ***See Attachment 2.3.2 for specific plans for Brockton and Good Samaritan Hospital EDs.***

Note: CCBC has recently begun outreach to the Brockton and Good Samaritan Hospital EDs with a goal of establishing a Memorandum of Understanding (MOU) on a hospital-specific plan to work with the ED staff. The attached plans represent the first step in the completion of the MOU. Discussion with two EDs has led to the EDs requesting consultation for patients that are boarding temporarily in EDs awaiting inpatient admission. CCBC will offer psychiatric consultation to ED physicians to assist them in managing patients while they remain in the ED; a practice that does not happen with any frequency at present.

2.3.3 Diversion from unnecessary psychiatric hospitalization and other out-of-home placement.

2.3.3.1 Brockton Diversion Experience. CCBC has an established track record of delivering community-based services such as PACT, CBFS, CSP and CBHI services that divert hospital admissions for both adult and child populations. CCBC also has experience at training community stakeholders, including law enforcement personnel, in preventing crises from escalating into higher risk situations that will precipitate a psychiatric hospitalization.

CCBC psychiatrists, including the CCBC Medical Director, Paul Weiss, M.D., also have experience working directly with ESP clinicians, hospital ED staff, and community stakeholders in managing psychiatric emergencies and diverting potential hospitalizations to the Community Crisis Stabilization program and other community-based alternatives. The seasoned staff that are part of the MCI contracted service for the Brockton ESP are also experienced at diverting hospitalizations in their mobile visits throughout the Brockton catchment area.

As the MCI provider in Brockton, CCBC will work closely with the Brockton Systems of Care Committee to develop safety plans that are family-focused and strength-based, and designed to keep the child in his or her natural community setting.

2.3.3.2 Creating a Culture inside CCBC to accept community-based alternatives. CCBC begins with a strong foundation of experience with the effectiveness of strategies to divert clients from inpatient hospitalization. In addition to the emergency psychiatry and MCI service, this experience derives from the operations of the Partial Hospital, Day Treatment, CSP, CBFS, PACT and CBHI programs. With the ESP program, CCBC will build on that foundation by providing concrete examples to the ESP staff of the client-centered, strength-based approach to clients in crisis in community settings that result in effective diversions. CCBC will also orient the ESP staff with presentations from peer specialists and family partners about effective diversions that underscore the recovery orientation of the CCBC programs, even for clients whose baseline symptoms may, at first, appear to meet hospital level of care, and can provide timely relief to the triggers that are individualized to the client's needs and preferences.

Creating a culture in the community and educating the community on alternatives. CCBC will build on the social marketing of the ESP features that include mobility to community settings, availability of peers, partnership with police, and 24/7 availability. The social marketing campaign will be expanded to explain the clinical criteria for the Community Crisis Stabilization (CCS) program, the availability of the MCI to children and their families for up to seven days, and the commitment to member safety. The ESP will further build the culture by providing specific examples of diversion from hospitalization, involving both adults and children as the program gains experience in the Brockton catchment area.

2.3.3.3 Specific Strategies For Diversion from Unnecessary Psychiatric Hospitalization

1. CCBC will strengthen three existing forums to create a culture, educate others, and increase working collaboration on effective and timely use of community-based

alternatives. The first is the *"Citizen X"* meetings that CCBC will utilize to identify high-ED users, clients who are immediate risk, or clients who have a history of frequent non-compliance with community resources and often revert to the ED.

2. The second forum is the DMH Risk Meetings, which are convened to discuss crisis planning for PACT and CBFS clients in the Brockton area. ESP's will build the capacity to share information on ESP evaluations with the community providers and, conversely, for the community providers to submit their crisis plans to the ESP, to be activated if the client presents for an ESP evaluation.
3. The CCBC ESP will expand the working relationship between CCBC psychiatrists and ED physicians to be available to confer with ED physicians to offer consultation, including recommendations for medication management while the individual is in the ED.
4. CCBC will become an advocate for the use of alternatives to inpatient hospitalization to the treatment community. The CSP and PACT programs are examples of the creative use of diversionary services in Brockton that promote recovery and client individual choice. CCBC will conduct follow-up meetings with referral sources to debrief on dispositions where the referral source disagreed with the outcome.
5. The CCBC ESP will also act proactively with the higher volume referral sources such as the Castle Program, the DYS program at the Brockton YMCA, and DCF residential programs in the catchment area. CCBC will meet with them regularly to clarify hospital level of care and the many viable alternatives offered by CCBC and other community providers. CCBC will seek to expand the CCIT program for Law Enforcement personnel in the Brockton catchment area.

2.3.3.4 CCBC does not expect to establish a "designated ED" model in the Brockton catchment area.

2.4 Recovery-oriented Services

2.4.1 Hiring Practices. CCBC has demonstrated in all of its programs an ability to recruit, hire and retain staff epitomizing recovery values that match the organization's mission. Its extensive outreach and community-based work guide a recruitment process that places a premium on finding the right candidates who understand and practice a recovery orientation. The agency attracts this type of staff person by virtue of the continuum of care it provides, the manner in which it provides these services, and the way the agency supports and promotes recovery resources, events, and initiatives.

2.4.1.1 The agency has also been a regional leader in employing persons with lived experience as evidenced by the hiring of peer specialists in its adult programs for the past 12 years, including those in PACT, Day Treatment, and the Elder Mobile Outreach Team, and for the past six years in our two CBFS programs. These peer positions have proven to be critical in increasing each client's level of engagement and receptiveness to that program's service model. This agency-wide pledge to uphold and prioritize a Recovery Model has been reinforced by our partnering with the Department of Mental Health to provide access to Person-Centered Planning training that allows for direct translation of an individual's goals and dreams into program objectives—further integrating the language of recovery into the work of all program staff.

CCBC is also the Community Service Agency (CSA) for the Taunton/Attleboro catchment area. In this model, all CSA staff are trained in the Wraparound model of recovery that focuses on *"family voice and choice"* and implementing a strength-based approach to engaging children with serious emotional disturbance (SED) and their families. In this CSA program, CCBC has

10 family partners—all of whom are parents of children with SED, who bring a strong and vocal vision of recovery to their work and provide a theme of authenticity for families struggling with complex and often acute behavioral healthcare situations.

2.4.1.2 CCBC has demonstrated a strong commitment to recruiting individuals with an established Recovery-based practice skill set. First, CCBC has recruited and hired family partners who have been fully integrated into our CSA program. These employees come from families who have received services from the CSA, and have lived experience of raising children with SED. Second, our CBFS and PACT contracts include peer specialists and staff that have been recruited based on their willingness to speak personally about their own experiences with recovery, their ability to provide support based on their life experiences, and are trained to support clients to help them move forward in their own path to recovery. Our recruitment strategies have included promoting available positions with the local Recovery Learning Community and the Transformation Center, reaching out to persons in recovery who serve on CCBC advisory committees, and networking with people who are active on any one of the community-based task forces that CCBC participates in.

The agency's management and supervisory staff have received training and support in developing interviewing skills with candidates to identify individuals who share the agency's commitment and dedication to Recovery beliefs and to putting the skills into practice. This recruitment support has proven itself indispensable in identifying positive, likeminded candidates who have become loyal and committed program staff that support recovery and work in collaboration with staff with lived experience.

2.4.2 Integration of Peers and Family Members

2.4.2.1 There are two members of CCBC's Board of Directors who are in recovery and one has a child with SED. Several enrollees in CCBC's PACT and CBFS programs also serve on CCBC's Human Rights Committee.

2.4.2.2 CCBC employs 14 peer specialists in the CBFS program and in its adult programs. Ten family members with lived experience involving a child with SED are employed as family partners in the Community Service Agency. One senior family partner is also a member of the MCI contracted staff in the current contract with the DMH-operated ESP program in Brockton. CCBC intends to hire both peer specialists and family partners as part of the ESP program staffing model. In addition, CCBC would incorporate recovery-oriented training for all staff. This would include contracting for training with the Transformation Center and others recognized for their articulate voices on the subject of recovery from the perspective of someone with lived experience. North Suffolk Mental Health Association's Director of Recovery would provide this training.

Peers participate in a long standing local cable television program, "The Other Side," focusing on recovery and featuring local community resources and CCBC clients in recovery. CCBC has produced over 100 shows to date. Peer specialists will be deployed to run groups in the CCS and provide support to clients and families.

2.4.2.2.1 CCBC's ESP program will have the benefit of the successful recruitment activities of CCBC's Human Resources Department to recruit, hire, and train peer specialists and family partners for the ESP. These strategies include outreach to the regional Recovery Learning Center, to parents who have completed involvement with the CSA program, word of mouth at local task forces and advisory groups that CCBC participates in, as well as traditional advertising in local and regional newspapers.

Both peer specialists and family partners who work in the ESP will have access to peer supervision as established in the CSA and CBFS programs. A senior family partner and a senior peer specialist will provide weekly supervision as well as ad hoc supervision as needed. Peer specialists and family partners will meet regularly with peer specialists and family partners in other programs to facilitate their learning and provide support.

2.4.3 Adherence to recovery principles

2.4.3.1 ***See Attachment 2.4.3.1***

2.4.3.2 CCBC's existing CBFS, PACT, Day Treatment, Partial Hospital, and CBHI programs all practice the principles of recovery as described in Section II.B, including the reference to SAMHSA and Section II.C. The elements of a strength-based approach that empowers the individual to develop a holistic plan are contained in the team-based approach with members' active participation in each of these four programs. The practice of including peer supports on the treatment team and working with the client are wholly integrated in the Wraparound Planning process and in the PACT, Day Treatment, and CBFS programs. The approach to members is individualized and holistic because clients are encouraged to identify their own preferences, supports, and solutions to ongoing treatment *as well as* to help them respond to any triggers that may put them at risk of harm to self or others. These supports include friends, neighbors, other peers, and 12-step programs, including the Dual Recovery Anonymous program started in Massachusetts by CCBC.

CCBC is experienced in respecting clients' preferences; staff are trained to be open to many different pathways to recovery that include natural community supports, and are accepting of the non-linear nature of recovery from mental illness, substance use disorders, and serious emotional disturbance in children and adolescents.

These principles and practices will be integrated seamlessly into the ESP through training and orientation of ESP clinicians, the presence of peers specialists and family partners and sharing with the ESP the successful examples from CCBC's current practices. In sharing these successes with ESP staff, the community-based interventions centered on client preferences will become a model for ESP staff to establish creative interventions that address clients with escalating symptoms in a community setting, deploying a full range of safe and effective holistic interventions. The peers specialists, and family partners are active members of the treatment teams. Another practice of these programs that is critical to the successful implementation of the recovery principles is the recognition that recovery is individualized and non-linear. The ESP will have staff – clinicians, peer specialists, and family partners – that can be flexibly deployed to address members' individualized needs during the course of a crisis episode. CCBC recognizes that effective engagement is best accomplished by understanding the stages of change as outlined in the techniques of Motivational Interviewing. The community orientation of the ESP will encourage engagement with the client in a setting that is comfortable and safe, and this will provide the best opportunity to engage the client and partner with them in addressing the psychiatric crisis.

2.4.3.3 CCBC recognizes that clients in psychiatric crisis present challenges to the recovery orientation in which dangerousness to self and others must be balanced with client choice and a strength-based approach. CCBC will address this challenge by training all ESP staff, including family partners and peer specialists, in the essential elements of client safety and dangerousness that relate to acute phases of mental illness and co-occurring mental health and substance use disorders. Within this frame, client choice and strength can still be activated and incorporated into the treatment plan, once the acute phase of the illness has been stabilized. The ESP will make a clear delineation to the clients at the outset of their right to refuse care to

promote client empowerment, but also be clear on the staff's obligation to make a judgment about client safety and risk of harm to others that will be balanced in the clinical disposition. CCBC has found that the clear delineation of these practices at the outset of the intervention assists in partnering with the clients.

ESP clinicians will also have access to timely clinical supervision and consultation with the ESP clinical supervisor, the ESP program director, and the ESP psychiatrists to address safety concerns and the soundness of diversion plans.

2.5 Culturally Competent Services

2.5.1 Population and related experience

2.5.1.1 By virtue of providing PACT, CSP and MCI services in Brockton and the surrounding communities, CCBC is very familiar with the racial, cultural, and linguistic composition of the area and the importance of delivering culturally effective services to its clients. With respect to demographics, Brockton is home to more people of color than Whites, which comprise only 42.9% of the population, and where the largest racial group is Blacks/African-Americans at 31.2%. Hispanic/Latino of any race is 7.8% of the population. Brockton has the largest population of Cape Verdean ancestry in the United States, with 9.0% of its population reporting this ancestry, and also has one of the largest communities of Angolans in the United States. Brockton has been making strides to rebuild the inner city to address the opiate problem and gang violence. A housing initiative has been started with a focus on empty housing units to provide additional affordable housing for low income and homeless families. The unemployment rate is 6.8%, 2.1 percent higher than the state average of 4.7% in June 2015. The remaining communities have a much higher percentage of individuals with a Caucasian background.

2.5.1.2 CCBC's current programs serve a diverse population linguistically and culturally: Latino, Hispanic, Portuguese, and Haitian cultures are represented in our client base, as are a number of languages in addition to English, including primarily Spanish, Portuguese, French, and Creole. CCBC strives to incorporate the Department of Public Health's Culturally and LinguisticallyAppropriate Services (CLAS)standards and guidelines with respect to trainings, staffing, brochures and staff languages, and to ensure that design, delivery, and monitoring of all services consider issues of race, ethnicity, culture, language, sexual orientation and gender.

The agency has a wealth of experience serving individuals from a variety of cultural and ethnic backgrounds. CCBC's local area includes a significant population of Portuguese and Spanish speaking residents. At present, CCBC has 27 staff persons who are bi/multi-lingual and available to do interpretation in languages that include Portuguese, Spanish, French, German, Danish, Somali, Arabic, Italian, Creole, and American Sign Language (ASL).

2.5.1.3 CCBC operates many services that are tailored both culturally and linguistically to meet the needs of the clients served, as reflected in the staffing in both its Community Support Program and Program of Assertive Community Treatment in Brockton. CCBC's CSP, which is made up of case management staff providing services to all of the communities this proposed program will serve, has the ability to work with clients speaking Portuguese, Spanish, and French Creole. Likewise, the PACT Team in Brockton serves a very diverse clientele that mirrors the population statistics in the city, and the staff is also quite diverse, including staff who are African-American and those who speak French Creole.

2.5.1.4 CCBC has been aware of the need to outreach the Asian community in all of our catchment areas as well as the French Creole population in Brockton. An effort to hire staff with cultural and ethnic backgrounds in this area and the ability to train other staff to understand the specific needs of these groups will be important to address any emergency

services or crises that may arise. CCBC will also make a concerted effort to engage leaders and resources in those communities to promote the availability of emergency services as well as other behavioral health services.

2.5.2 Organizational capacity

2.5.2.1

2.5.2.1.1 The composition of the CCBC Board of Directors is currently made up of men and women who are Caucasian, with varying cultural backgrounds and linguistic capabilities, as well as those in recovery who bring critical perspectives to the agency. CCBC's senior management includes a team of vice presidents, program managers, and team leaders, as well as a clinical team that includes individuals in positions of critical importance to the agency who are Caucasian, African-American, Cape Verdean, and African. It is CCBC's plan to increase the number of board members, senior managers, as well as others in critical positions, particularly in the ESPs, who will represent the racial and ethnic population found in the Brockton service area that have experience providing culturally competent behavioral health services.

2.5.2.1.2 CCBC's Board of Directors (BOD) has taken on the initiative to develop Advisory Boards for the agency to meet the needs of specific programs. One example of this includes The Consumer Advisory Board (CAB) which serves the Greater Taunton Area's HIV-positive Community. It monitors services provided and reviews programs to ensure they are living up to what they are contracted to do. The CAB seeks to have as diverse a membership as possible so that the perspective of all People Living With HIV/AIDS (PLWHA) in the Greater Taunton Area is represented. Currently one CAB member is hearing impaired, one is Hispanic, and one is African-American.

2.5.2.1.3 CCBC seeks to ensure that staff members reflect the cultural and linguistic characteristics of the population served, and as such we are committed to providing services that acknowledge and enhance the dignity of all with a particular recognition and focus on the MassHealth-enrolled population. CCBC currently has 27 staff who are bi/multi-lingual and available as interpreters. Languages spoken include Portuguese, Spanish, French, Somali, Arabic, Italian, French, Haitian & CapeVerdian Creole, Romanian, and American Sign Language (ASL).

2.5.2.1.4 CCBC uses its internal capacity for interpreters first as described above in 2.5.2.1.3, and if necessary employs the local interpreter services available through a service we have contracted with "Optimal Phone Interpreters" who provide instant interpretation in any language. The process is as follows: 1) *Call OPI:* Call 1-877-Ring-OPI (1-877-746-4674); 2) *Connect:* OPI asks what language and confirms your location 3) *Interpret:* Speak directly with an OPI interpreter. OPI also offers CCBC video remote interpretation for communicating with the deaf and CCBC also offers sign language interpreters through the Massachusetts Commission for the Deaf and Hard-of-Hearing, Deaf Inc., and other local providers that are available by developing a memorandum of understanding. At time of hire, all CCBC staff is asked to complete a form that lets HR know what language capability they have and their willingness to be involved in interpreter services for other agency programs, in addition to the program they are working in.

2.5.2.1.5 ***See Attachment 2.5.2.1.5.***

2.5.2.2 CCBC's mission statement clearly addresses the need for culturally competent services as a priority for the agency:

"To develop and deliver compassionate, responsive, culturally competent, and quality mental health and substance abuse services to meet the prevention, education, treatment, rehabilitation and recovery needs of those in our community. These services are based on

the latest evidence-based approaches to respond to the complex needs of children, adolescents, adults, elders and families as part of a locally integrated health-care delivery system linked to regional and statewide delivery systems."

CCBC has recently completed a total revision of our policy and procedure manual and our employee manual, both including a focus on cultural competency and the need to include definitions, values, and respect for the various cultures we serve as well as the staff that work for the agency.

2.5.2.3 CCBC has developed training for all staff that will increase awareness, understanding, and cultural sensitivity of the diverse populations in the communities that CCBC serves. All of the strategies to ensure cultural and linguistic competency at CCBC are based on the following definition adopted by CCBC: ***The knowledge and interpersonal skills that allow individuals to understand, appreciate, and work with, people from cultures other than their own.***

CCBC also incorporates the following expectations into our agency and staff practices regarding cultural competence:

- Cultural Awareness: Every culture holds distinct biases, values, beliefs, practices, lifestyles, and problem-solving techniques which can affect clients' use of health services;
- Cultural Self-Awareness: Staff has awareness of our own biases, values, beliefs, practices, lifestyles and problem-solving techniques that may affect interactions with those they work with, from their own or other cultural groups;
- Cultural Respect: Treat all clients with dignity, consideration for, and understanding of the value they place on their beliefs;
- Cultural Knowledge: Staff have 1) in-depth knowledge of one or more cultures, including concepts of illness, family context, and other factors impacting health and health behavior; and 2) knowledge of illnesses and conditions more common among individuals of particular races and ethnic groups;
- Cultural Assessment: Staff assesses the extent to which clients' beliefs are aligned with those typically associated with his/ her culture of origin;
- Cultural Adaptation: Staff reasonably adapts their approach to clients' cultural values, beliefs, practices, lifestyles and problem-solving techniques.

2.5.3 CCBC will build upon its already established strong working relationships with the local providers from minority, community-based, and mutual assistance organizations to emphasize the additional capacity to serve their members who are experiencing a psychiatric crisis. This expanded relationship will extend to a larger network of organizations in the Brockton catchment area. CCBC has developed partnerships with minority, community-based organizations, and other multi-service agencies for immigrants and refugees to meet the care and support needs of our clients. The partners include the Haitian Community Partners and the Cape Verdean Association of Brockton, who have worked closely with our CSP and PACT programs serving the Brockton area. One example of our collaboration with the Haitian Community Partners was that CCBC was able to address the cultural and linguistic barriers to the effective treatment of a Haitian immigrant who was suffering from both acute medical as well as psychiatric illnesses. The Cape Verdean Association offers individuals in CSP volunteer opportunities and English as a second language classes. Both of these organizations have provided assistance to individuals in navigating immigration-related issues.

2.6 Other special populations

2.6.1 Elders. CCBC has a program dedicated to elders serving clients in the Taunton/Attleboro area funded by Title III funds of the older Americans Act, Bristol Elder

Services and Executive Office of Elder Affairs. This program, the "Elder Mobile Outreach Team" (EMOT) provides urgent care to elders with behavioral health care needs.

2.6.2 Veterans. CCBC serves Veterans who are homeless through CCBC's Community Support and Housing Partnership programs (see 2.6.3 below). CCBC's ESP will have access to case consultation to this program when a Veteran presents in psychiatric crisis.

2.6.3 Persons who are homeless. CCBC has developed a successful housing partnership in Taunton with property owners, city housing authority officials, DMH, and homeless shelters to provide clinical, social and housing supports to clients at risk for chronic homelessness. CCBC recently received a three year grant from the Substance Abuse and Mental Health Services Association (SAMHSA) to address the support needs of chronically homeless veterans and others in the community who require additional supports to gain and sustain adequate housing.

2.6.4 Persons with substance use conditions. CCBC's outpatient clinics are licensed by BSAS as substance abuse clinics with accompanying expertise in treating substance use disorders. The orientation for ESP clinicians will include training in substance use disorders, including screening and motivational interviewing.

2.6.5 Persons with co-occurring mental health and substance use conditions. Between 50 and 75% of ESP clients in any given month present with a co-occurring disorder. CCBC's clinical staff have established clinical protocols in the assessment, diagnosis, and treatment for persons with co-occurring conditions that addresses the functional barriers the client is facing. These protocols will be part of the ESP assessment.

2.6.6 Persons who are deaf and hard of hearing. CCBC will receive training on work with persons who are deaf and hard of hearing from North Suffolk Mental Health Services who has a specialized CBFS and community support services for this population. CCBC also has staff with competence in American Sign Language.

2.6.7 Persons who are blind, deaf-blind, and visually impaired. As necessary, CCBC utilizes the consultation of regional Mobility and Orientation Specialist Donna DiCorpo, M.Ed., who has worked for over 30 years for a vendor of the Massachusetts Commission for the Blind, as well as having a private consultation practice.

2.6.8 Persons who are involved with the Department of Mental Health (DMH). As the CBFS provider, CCBC is the leading provider of services to persons who are involved with the Department of Mental Health in the Taunton/Attleboro area. CCBC operates outpatient clinics in Taunton, and Attleboro and PACT teams in Taunton and Brockton. CCBC has well-established protocols for this population that include access to ESP's and ESP interventions in community-based settings as part of the client's Wellness Recovery Action Plan and the client's Safety Plan.

2.6.9 Youth and families involved with the Department of Children and Families (DCF). About 50% of children presenting to the ESP are involved with DCF. CCBC works with the DCF Area Office in an Advisory Capacity. The CCBC CSA engages DCF to participate in the Taunton/Attleboro Systems of Care meetings that include the role of MCI as a part of the intervention and safety plan for the child and family.

2.6.10 Youth and families involved with the Department of Youth Services (DYS) and/or the juvenile court system. CCBC is the designated CSA for the Bristol County Juvenile Diversion Project that involves the Bristol County Juvenile Court, Probation Officers, the Court Clinic, and other Law enforcement officials.

2.6.11 Youth who are on the Autism Spectrum. Paul Donnelly, Ed.D., a consulting psychologist to CCBC, is experienced with this population. He will provide consultation and

training to the ESP staff on working with this population when they appear in crisis and with escalated behavioral presentations.

2.6.12 Persons who are receiving services from Department of Developmental Disabilities (DDS). Paul Donnelly, Ed.D., a consulting psychologist to CCBC with considerable experience with those with developmental disabilities will provide consultation and training to the ESP staff on working with this population when they appear in crisis and with escalated behavioral presentations that can often be managed more successfully in settings outside of an ED and an inpatient hospital.

2.7 Intersystem planning and affiliation

2.7.1 CCBC is well known in the Taunton/Attleboro area and throughout Bristol County for its organizational commitment to collaborating with other providers, payers, advocates, and clients to create integrated systems of care. CCBC has taken leadership in a number of community projects and CCBC is the conveyor of projects such as:

- The Continuum of Care for Greater Bristol County Attleboro/Taunton Coalition to End Homelessness, which includes the Mayors of Taunton and Attleboro, local housing authorities, Department of Mental Health, and human service providers and local businesses, and CCBC manages one million dollars in HUD funding annually on behalf of the Coalition;
- The Systems of Care meetings convened by the CCBC CSA comprising all local stakeholders involved with youth: DCF, DYS, local schools, day care providers, juvenile court, and after school programs;
- CCBC chairs the Taunton HIV Consumer Advisory Board (CAB) to reduce stigma and ensure access to services for persons with HIV/AIDS; and
- The Mayor's Opiate Task Force in Taunton is co-chaired by a CCBC senior manager, along with the city's director of human services.
- CCBC convened a local Committee to gather support for a SAMHSA grant to service homeless veterans. A three year contract has recently been awarded to CCBC, and this group will serve as the grant's Steering Committee and includes: DMH, BSAS, MBHP and others.
- CCBC convened a local coalition group of healthcare, behavioral healthcare, and public health professionals to develop a proposal to the Health and Wellness Trust Fund of DPH.

2.7.2 CCBC will expand the culture of collaboration in the Taunton/Attleboro area into the operation of the ESP in the Brockton catchment area. CCBC will work closely with the key stakeholders and build new relationships to actively work towards the goals of timely response in a community setting.

CCBC recognizes that as a new ESP provider working with a very visible and high need population, that establishing credibility is the most important step. We will engage with stakeholders by establishing several principles that will guide the collaboration:

- A data-driven approach is the best method to solve problems;
- Each stakeholder deserves a timely, polite response that emphasizes the value of fully understanding the issue of the person(s) working with the ESP;
- Solutions are best developed in collaboration; and
- In psychiatric crisis, there will always be unusual clinical presentations that are best solved in a calm, accepting, and collaborative atmosphere.

First, CCBC will establish a working group to help CCBC ESP managers and staff implement the new program and provide a forum to review progress and address key issues in

the operation of the ESP. The working group will be co-led by the ESP program director and the ESP medical director. It will consist of representatives from all of the important stakeholders including, both hospital EDs, DMH, DCF, and DYS Area office staff, the Brockton CSA, the Brockton Community Health Center, and the local NAMI affiliate.

Second, CCBC will distribute information using multiple media about the operation of the ESP, that highlights 24/7 phone availability, access to the Community-Based Location, mobile capacity, and the seven-day model of MCI intervention. This will be followed up by face-to-face meetings by ESP staff.

Third, CCBC will develop measurement tools that will provide a data-driven approach to the success of the implementation. These reports will allow CCBC to be responsive to the priorities reported to them by the community stakeholders, including telephone responsiveness, responsiveness to the ED, and access to the CCS.

Fourth, CCBC will establish a subcommittee of the working group to form Critical Risk Teams to include peer specialists and family partners. The teams will develop safety plans with the clients to help the client and his/her family maximize their safety through the use of less restrictive alternatives. This group will be chaired by the clinical director of the ESP.

Finally, CCBC will undertake a Performance Improvement (PI) initiative to survey persons who come directly to the hospital EDs to determine their knowledge of the ESP, the pathway that resulted in directly coming to the ED, and their willingness and the willingness of the referral source to consider alternatives in similar circumstances. This PI effort will help the community stakeholders identify the **root causes** of reliance on the ED so that they target corrective actions in the most effective direction.

2.8 Staff training, monitoring, and evaluation. CCBC will enhance our current training, development, and evaluation of staff to include the goals of timeliness of response, diversion from the ED, increased mobile visits, and reduced reliance on inpatient hospitalization.

All CCBC staff positions have a set of core competencies that are established for the position. A set of required internet-based and in-house video trainings and live training sessions are established to align with the core competencies. Staff complete the required trainings, each of which includes a test that must be passed before credit for the course is given. Training also includes shadowing seasoned ESP clinicians. Once the clinician is conducting assessments independently, the clinician has to review the findings and recommendations with the CCBC Administrator-On-Call (AOC) in order to complete the intervention. Before the clinician attains complete autonomy, s/he must pass the ESP clinician *"Competency Test."*

Competency will be maintained through monthly staff meetings, weekly supervision for Clinicians seeking licensure, and case-by-case supervision for all staff when needed. The AOC is available for case consultation at any time.

CCBC will also work with staff to improve the overall performance of the program through a number of Program Evaluation Indicators. One is the Consumer Satisfaction survey which is aggregated twice a year by CCBC's Quality Management Coordinator. Previous outpatient surveys have resulted in a performance improvement effort to address waiting time in outpatient services. The corrective action was the development of a "Rapid Access Project" that provides same day access to outpatient services.

The CCBC QM staff will also measure the performance of the ESP on key indicators related to the timeliness of telephone and face-to-face response, the percentage of mobile visits for children and adults, the percentage of community-based and ED face-to-face contacts, and the use of alternatives to inpatient hospitalization.

3. ESP service components: (100 points)

3.1 Emergency Services Program (ESP): overall program

3.1.1 Provide a brief program description that summarizes your overall ESP program model addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

3.1.1 Since its inception as an organization Community Counseling of Bristol County, Inc. (CCBC) has tirelessly pursued the development of a comprehensive, recovery-focused integrated system of behavioral health in Bristol County and the Southeastern region of Massachusetts. We take pride in providing a broad array of innovative services to persons – adults and children – struggling with mental health and substance use disorders so that they and their families may live full and functional lives in their communities. CCBC views the Emergency Services Program (ESP) as a critical, distinct level of care in the behavioral health delivery system, sitting at the nexus of acute and sub-acute services for adults, children and adolescents.

In our experience, early and effective intervention is invaluable as a means of promoting resiliency and recovery, while also preventing potential crises from becoming more protracted, painful and costly episodes of care. Central to this effort is a team of capable clinicians, peer specialists, family partners, and psychiatrists who are experienced at engaging the client and family rapidly and respectfully. Our experience has demonstrated that the fullest participation of the client in the process leads to the best treatment outcomes. Our role is to respect the client's preferences in arriving at an appropriate disposition with a shared vision of long-term recovery. In summary, our philosophy is to provide timely intervention in a variety of community settings that promote the best opportunity for client engagement, participation, and recovery. CCBC is proposing to operate ESPs in two catchment areas in the Southeast: Brockton and Taunton/Attleboro, to enhance the resources of both sites with a larger pool of clinicians, peers, and family partners to meet the fluctuating demand in the Brockton area.

CCBC will establish an ESP that has ESP clinicians available 24/7/365 to respond to psychiatric crises in the Brockton catchment area. A clinician will be available from the initial phone call for triage, brief counseling, and face-to-face interventions, as well as evaluation and consultation with ED staff, family, other providers and referral sources such as DMH, DCF, schools and local law enforcement. Once the evaluation is completed, the ESP team will develop an intervention that begins in the community and includes a holistic plan with the member's strengths and preferences considered at each step. With an accessible community-based location, the ESP first point of contact will begin in the community and not in the ED.

Based on implementation of the ESP, CCBC proposes to strengthen the model in the Brockton catchment area with a higher percentage of mobile crisis interventions outside of the local hospital EDs. We are proposing a community-based site with 'walk-in' capacity at 157 Main Street, which will be built out to include a 6-bed Community Crisis Stabilization program.

Flow of Services. From the client's perspective, contact with emergency services will usually start with a phone call to the Brockton Community-Based Location (CBL). The community-based-sites in Brockton and Norton will also have mobile capacity. However the initial contact occurs, the first priority of the ESP team is to assure client safety and the safety of those around them. Some cases are able to be resolved over the phone; others may require face-to-face crisis counseling, and some may be appropriate for direct admission to the CCS. CCBC believes that it can successfully triage ESP encounters and divert them from the ED, decreasing the percentage of ESP assessments conducted in EDs to below the statewide average.

CCBC's intervention model includes not only immediate stabilization of clients in crisis, but also assurance that they are properly linked to appropriate and necessary follow-up supports and clinical services. For children and their families, the Mobile Crisis Intervention (MCI) will include support for the child and family in the seven-day window following the crisis, and transition to other supportive services, such as In-Home Therapy. Working with people at their most vulnerable, the philosophy of the ESP is that the clinician has the opportunity to support the client in a thorough and honest evaluation of their circumstances and to match their needs to a strength-based plan for recovery in a community setting, whenever clinically appropriate. That plan draws upon holistic resources, including a seven-day intervention with children and families and direct admission to the CCS for adults. Follow-up includes securing the necessary services for a safe and timely disposition, including the search for a 24-hour program, and follow-up with the referral sources and family to inform them of the outcome. CCBC has a long track record of working closely with the entire spectrum of healthcare, behavioral healthcare, housing, and human services providers in the Brockton and Taunton/Attleboro areas to assure that clients are able to access the care they need.

The staffing pattern for the ESP in the Brockton catchment area includes a 24-hour per day staffing of Master's level clinicians scheduled to respond in person within the required timeframes to the volume demands in the catchment area. All clinicians perform all of the core ESP services of crisis assessment, intervention, and stabilization services listed in the MBHP Performance Specifications, regardless of client location. These core clinical staff will be complemented with 1.5 FTE certified peer specialists and 1.7 FTE family partners. The entire ESP operation will be supported by a rotating group of psychiatrists totaling .8 FTE's and administrative staff to assist in scheduling and billing. The Brockton CCS will be staffed by a R.N. nurse manager, counselors during the day, and LPN's and a counselor on evenings, nights, and weekends.

All clinicians will be available for mobile visits. Eighty percent of the clinicians will be trained to be child/family competent at the time of implementation, and CCBC intends to train and credential the remaining clinicians to be both adult and child competent within three months of implementation.

Another key element of the philosophy of the program is high visibility with community stakeholders. CCBC will complement the delivery of ESP direct services with an active presence in the community through participation in forums sponsored by DMH, the Brockton CSA's Systems of Care, and the Good Samaritan and Brockton Hospital EDs. CCBC will also encourage, sponsor and participate in trainings for the law enforcement and public safety personnel in Brockton and surrounding communities built on the Community Crisis Intervention Training (CCIT) that has been so successful with the Taunton Police Department. The CCBC Brockton ESP will engage in joint planning with local hospitals on emergency services diversion. The current presence of CCBC's psychiatrists in the current ESP and the community visibility of CCBC's PACT Team and Community Support Program (CSP) will support a smooth implementation of the CCBC Brockton ESP and engagement with community stakeholders.

How shall you change the perception which may exist in your organization and/or in your community that the ESPs function is to conduct "hospital screening"? What operational and cultural changes shall your organization make to ensure the delivery of ESP services

that consist of a comprehensive and discrete level of care, incorporating crisis assessment, resolution-focused intervention, and stabilization?

CCBC will implement the ESP with the foundation that the community is the continuum of care for psychiatric interventions. The continuum includes telephone triage, open communication with the referral source as the evaluation is progressing and exploring community resources to match the member's needs. CCBC believes that this proposed model of operation of the Brockton ESP is congruent with the MBHP's description of the ESP service. The CCBC Brockton ESP will extend beyond a program that operates as a "*hospital screening*" program to include a continuum of care for both adults and children that offers a range of choices at each step of the crisis intervention, from telephone triage to final disposition. CCBC has established an internal culture of meeting clients in a range of community settings through our Brockton PACT, Brockton CSP and full continuum of CCBC programs in Taunton/Attleboro, that include CBHI services. We see a number of opportunities for improvement in establishing the Brockton ESP as a continuum of care based in the community:

- CCBC welcomes the opportunity to include the consumer voice in crisis intervention with the enhancement of the position of Certified Peer Specialist (CPS). Including a CPS as part of the team will provide an immediate, ongoing reminder of what it is like to be on the receiving end of behavioral health services and provide an additional resource to clients in psychiatric crisis that extends beyond hospital screening and increases options for diversion. CCBC has had success with CPS and FPs by incorporating them directly into CBFS and CBHI program operations.
- CCBC also looks forward to creating a distinct child/adolescent mobile crisis intervention team, complete with Family Partners. We have relevant experience with children in crisis through our Taunton/Attleboro CSA, which convenes Systems of Care meetings to develop and coordinate Safety Plans for families that involve the MCI. CCBC also provides staff as MCI contracted services for the current ESPs in Brockton and Taunton/Attleboro. The Brockton ESP will collaborate closely with the BAMSI Community Services Agency (CSA) that covers the Brockton catchment area.

Based on relationships already established in the Brockton catchment area, CCBC will change the perception of the ESP in the community through continuing outreach to police, schools, mental health providers, health centers, homeless shelters, and the hospital EDs on the utility of mobile crisis outreach. New and improved visibility of the ESP to these stakeholders will provide a foundation to shift the reliance for emergency intervention *away* from the ED to other community settings. Demonstrated ESP capacity in community settings such as Community Health Centers will also result in less inconvenience for their members.

CCBC will initiate a sustained social marketing campaign to educate clients, families, providers and other referral sources and stakeholders on the expanded hours and capabilities of the community-based sites and will also highlight the value of mobile crisis interventions for adults and children and their families in other community settings.

CCBC's strategy will include community meetings with key stakeholders at which concrete examples of the value of mobile crisis intervention will be shared. We will also survey the referral sources on an ongoing basis to identify the root causes of the current patterns of referral and incorporate those findings into the social marketing strategy to emphasize the capacity of the ESP to provide crisis interventions in community settings outside of the ED.

CCBC will provide training for the telephone triage staff to complete a standardized set of questions with the referral source to complete an assessment, resolution-focused intervention and disposition of the psychiatric crisis. CCBC will also work with the local ED staff to gather the same information. The triage staff will explore the reasons for the call, the feasibility of a mobile visit, and the source of the referral to the ESP. CCBC will use the findings to provide ongoing discussion with all ESP staff and the referral sources about the patterns of the calls and the viability of mobile visits. The ESP managers will brainstorm methods to address the obstacles that emerge from the findings.

Finally, CCBC will provide community stakeholders with tools to effect community-based evaluations, including Wellness Recovery Action Plans (WRAPs) used for adults in the DMH service system, Safety Plans for Children with SED and their families, and other outlines designed to inform stakeholders of steps to take to keep the client in a community setting. Another tool is the Community Crisis Intervention Training that CCBC has overseen successfully through the CCIT and the Taunton Police Department. CCBC will seek to replicate that training in Brockton. Useful experience with these tools will provide an alternative to the default reaction of dialing 911 in a psychiatric emergency.

3.1.3 Describe how you shall realize the vision and manage your ESP program, inclusive of all service components, as one integrated continuum of emergency services responsible for meeting the emergency behavioral health needs throughout the proposed catchment areas.

CCBC welcomes this RFR as an opportunity to establish a regional ESP with accompanying efficiencies in service delivery, a team of Certified Peer Specialists (CPSs) and Family Partners (FPs), and a larger pool of ESP clinicians who can provide timely crisis interventions in all of the communities in the Brockton and Taunton/Attleboro catchment areas. CCBC will realize the vision of the ESP that follows from our established culture of community-based care for persons with mental illness, substance use disorders, and serious emotional disturbance. CCBC operates that model with key components that parallel the ESP requirements: flexible deployment of staff to meet fluctuating demand; skill and competency at providing an individualized intervention based on the clients' strengths, needs and least restrictive pathway to stability and recovery; capacity to deploy a team-based approach with CPSs and FPs as full participants; and knowledge and familiarity with the communities in the Brockton catchment area to conduct safe and effective crisis interventions.

The integrated continuum of services will be enhanced with a combined Community Based Location (CBL) and the Community Crisis Stabilization (CCS) program that will include nursing staff that will be available around the clock to check vital signs. ESP triage staff will be available to assist CCS staff in managing behavioral crises on the unit and assisting with the treatment program involving group, individual and family counseling. All master's level clinicians regardless of their assigned location will function as mobile clinicians, responding to all community requests for mobile crisis intervention.

The Child Mobile Crisis Intervention (MCI) Team will have full access and back up of the entire CBL and its functions, since 80% of the ESP clinicians will be child-trained at the time of implementation. Within three months of implementation all ESP clinicians will be available to conduct Child Mobile Crisis Interventions.

In short, CCBC views the ESP as the emergency room without walls, handling the full range of psychiatric interventions: telephone triage, mobile crisis visits, next day follow-up, linkage to ongoing treatment in the community, initiation to treatment, or disposition to more intensive 24-

hour level of treatment when indicated. The model will be enhanced with the additional support available to adults and children through the CPS and FP as resources for the clients and their families that can contain the crises in home and community settings. This model will provide the best opportunity for a strength-based, individualized approach to clients in crisis with a greater frequency of community-based mobile interventions outside of the ED. CCBC will realize this vision by increasing the percentage of mobile visits and strengthening links with other providers to reduce the existing practices among many referral sources of sending persons in crisis directly to the ED.

On the occasions when members are admitted to the EDs at either Brockton Hospital or Good Samaritan Hospital, CCBC will have clinicians on-site during peak demand periods to provide more responsive interventions and to build working partnerships with the ED staff.

The ESP program director will work with the CCBC Quality Management staff to identify key measures related to the percentage of mobile visits and timeliness of response to actively manage the pursuit of the vision. CCBC has established a strong foundation to engage in performance improvement initiatives across the agency.

3.1.4 Describe how your ESP program shall operate in a fashion that ensures fluidity among its service components, including how you shall use your staff resources in an integrated and flexible manner, while accommodating fluctuations in volume, location of services, etc. Please include your strategy to address seasonal variations in volume as well as variability among shifts.

As mentioned in 3.1.3 above, ESP staff will be cross-trained to provide interventions to both children and adults and to cover both catchment areas as needed based on fluctuating demand. Any staff member can offer real time assistance and fulfill the functions of the various components on an as-needed basis. CCBC is also proposing to create "*hybrid*" positions that cover all seven days of the week and that can be shared at both sites. These hybrid staff will be hired at reduced level salaried positions with full time benefits and will receive additional payment for each evaluation completed. CCBC retains these staff by paying them a case rate in addition to their base salary, giving them an incentive for efficient responsiveness, while at the same time containing costs. They can respond to peaks in volume for children or adults in both catchment areas when there are staff shortages, high client volume, or combinations of both.

From consultations with other ESPs who have developed this model, the effect of such positions will have a positive impact on the ESP operation in the Brockton catchment area. First, the client will benefit from a quick response. Second, the hybrid staff member will be employed with a full benefit structure. Third, the teams as a whole will be less stressed by inevitable staff vacancies and spikes in client volume which, without such a "safety net," have the potential to exact a toll on staff morale and productivity. This "*fire-house*" model will allow CCBC to be responsive within the expected timeframes on a day-to-day basis, and will add stability and continuity to the program and strengthen CCBC's capacity to provide high quality, consistent service. An effective crisis clinician needs to have their basic hierarchical needs of safety, predictability, and security met, so they can meet the needs of the population in the Brockton catchment area requiring crisis intervention.

CCBC will also employ a "*courtesy*" evaluation strategy for peaks in volume. This is a system wherein the agency will have a protocol to tap into our existing staff roster by calling ESP staff who are off duty, but who may be available and interested in responding to a case or two for an established case-rate of pay. Similarly, CCBC has an extensive roster of appropriately trained adult and child clinical staff on which it can draw to augment the ESP clinical staff on

nights, weekends and during periods of unusual heavy demand. These mechanisms will allow us to be creatively responsive to client needs.

The CPS can facilitate skill building in systems navigation and development of coping skills for CCS clients in group counseling sessions and also engage in peer counseling and support for walk-ins to the community-based location. CCBC has established training, orientation, supervision and other supports for peer specialists in their PACT, CBFS, and Day Treatment programs that will include the ESP as part of the implementation.

Our strategy for addressing seasonal fluctuations in Brockton involves several elements: First, CCBC's Human Resources Department and the ESP program director will add on-call and relief staff during the October to mid-December and mid-January to May time periods when volume tends to escalate the most. Second, the Brockton ESP program director will proactively meet with high volume referral sources to identify any preventive steps that can be taken with ESP staff, including peer specialists, to keep the client safe and stable in his/her home environment and reduce the need to refer the client to either Brockton or Good Samaritan Hospital ED. Finally, the ESP clinicians will notify the ESP program director and ESP medical director when any high-profile, high-risk, or complex cases are first evaluated so that the Managed Care Entity to whom the member has been assigned, state agency representatives from DCF, DYS, DDS and DMH, MassHealth, and other key stakeholders can be brought into a clinical discussion around disposition before the client has experienced an extended stay in the ED. Examples of these types of cases include persons with serious mental illness who have recently been released from prison, children with developmental disabilities and co-occurring serious emotional disturbance; and juveniles committed to DYS for violent offenses presenting with suicidal or homicidal ideation.

3.1.5 Describe how your ESPs 800number and triage function shall operate, noting any variance by time of day or day of week.

CCBC will establish a centralized triage function based on other innovative models in current ESPs. An ESP clinician will be available to answer the phone to initiate telephone triage 24 hours per day, seven days per week, 365 days per year. We propose to manage calls during normal business hours at the Brockton CBL from 8am–8pm, Monday–Friday. Initial triage during the day shift will be handled by an experienced BA-level staff, with immediate back-up from on-site ESP licensed clinicians. During evenings, there will be one ESP clinician at the CBL and one clinician at one of the Hospital EDs. After hours all calls are answered by a licensed clinician as part of the Brockton ESP. If all three clinicians are involved in a face-to-face evaluation, the calls will be automatically routed to the Taunton/Attleboro ESP and are answered by an on-call licensed clinician. As noted in the previous section, there is at least one licensed clinician available to receive calls 24 hours each day, 7 days per week, year round.

Clinicians staffing CCBC's ESP will have 24/7/365 access to the ESP program director, the ESP clinical supervisor, and psychiatrist through an on-call system. These staff will respond to all pages within 15 minutes per the MBHP performance specifications. The CCBC psychiatrists also work in other CCBC programs, including PACT, Day Treatment, CBFS, and outpatient settings and are familiar with the CCBC client population. The Brockton ESP will operate an "Administrator-On-Call" rotation with supervisory back-up 24/7/365 for ad hoc clinical supervision from a clinical manager on call and a psychiatrist to help with resolution of "systems issues" and complex clinical presentations. This Central Triage will cover both the Brockton and Taunton/Attleboro catchment areas to ensure timely access to an expanded pool of clinicians and

centralizing critical information in one agency. MBHP will gain efficiencies and consistency in operations with a regional approach.

3.1.6 Geographic coverage; Does your organization have resources such as various locations you can leverage, as part of your strategy?

CCBC has an office site in Brockton and numerous staff who already work in the Brockton PACT and CSP programs. Some of these staff can function as ESP relief clinicians to supplement ESP staff. In addition, CCBC is proposing a single administrative structure to the ESPs in Brockton and Taunton/Attleboro to provide additional resources and administrative efficiencies to the Brockton catchment area.

The CCBC ESP Community-Based Location will share a co-location with the Brockton CCS program. The communities in the Brockton catchment area do not require long travel times from the Brockton Community-Based Location (CBL).

3.1.6.1 The strategic location of the CBL at 157 Main Street in downtown Brockton will ensure that all mobile visits in the catchment area available within a 30-minute drive.

CCBC will develop creative staffing strategies involving hybrid clinicians described in section 3.1.4 and placement of clinicians at the Brockton and Good Samaritan Hospital EDs during certain weekday evening shifts to address the fluctuations in volume as the need arises. CCBC will have the capacity to respond to any "hot spots" in the Brockton catchment area, such as the Brockton Hospital ED, with an expanded roster of ESP clinicians from two catchment areas that will meet or exceed the response time standards established in this RFR. As noted above, CCBC has a roster of dozens of clinicians with the necessary training, including supervisory staff, to back up dedicated ESP staff to assure timely response and exceed MBHP performance standards, particularly during peak demand and during any start-up period.

3.1.7 The regional approach proposed by CCBC will assure MBHP of a consistent approach for the Brockton and Taunton/Attleboro catchment areas.

CCBC will also address the high volume demand at the two hospitals in the Brockton Area– Brockton Hospital and Good Samaritan Hospital, with a clinician available to be posted at each Hospital ED from 3-11pm and 11pm–7am for up to five days per week, Monday through Friday, and available to be on-site as needed during peak demand times on weekends and holidays. These clinicians can be deployed elsewhere in the catchment area to provide mobile crisis interventions upon request from the triage clinician.

3.1.8 Location of services:

3.1.8.1 Please provide general information about the planned location(s) of ESP functions and services as well as hours of operation:

Service Component	Address(es) where Service will be Delivered or Dispatched From	Days/Hours of Operation		Other Services at this Location
		Of the Service Component	Of the Physical site	
ESP Management Function	Executive Management: CCBC Taunton Main Office 1 Washington Street, Taunton Program Management: 157 Main Street, Brockton	8:30am – 5pm, M–F	8am–8pm	CBFS, CBHI, PACT Outpatient, PHP
800 number and	Brockton CBL – 157 Main	24/7/365	24/7/365	CCS

triage	Street, Brockton			
Community-Based Location	Brockton CBL – address TBD	8am – 8pm, M–F	24/7/365 8am–8pm, M–F	CCS
Youth Mobile Crisis Intervention	Brockton CBL – 157 Main Street, Brockton and from CCBC Main office as needed for back up volume	24/7/365 24/7/365	24/7/365 8am–8pm, M–F	CCS, Outpatient
Adult Mobile Crisis Intervention	Brockton CBL – 157 Main Street, Brockton and from CCBC Main office as needed for back up volume	24/7/365 24/7/365	24/7/365 8am–8pm, M–F	See above
Adult CCS	Brockton CBL – 157 Main Street, Brockton	24/7/365	24/7/365	ESP,CRS, ACT,QM
Run Away Program (RAP)	Brockton CBL - 157 Main Street, Brockton	4:30pm – 8am; 24 hours, weekends and holidays	8:30am–8pm, M–F	CCS

3.1.8.2 CCBC is currently considering available space at 157 Main Street, Brockton for the co-location of the CBL and the CCS. Upon award of the contract, CCBC will move to complete the lease and build out the space to comply with contract requirements.

3.1.9 ESP management

3.1.9.1 Please attach resumes, or if not yet hired, please describe hiring qualifications of the following positions:

3.1.9.1.1 ESP Program Director – *See Attachment 3.1.9.1.1*

3.1.9.1.2 Quality/Risk Management Director – *See Attachment 3.1.9.1.2*

3.1.9.1.3 Medical Director – *See Attachment 3.1.9.1.3*

3.1.9.2 Attach an organization chart that indicates where these and other key ESP staff shall sit within the organization at an administrative and supervisory level.

See Attachment 3.1.9.2

3.1.10 Psychiatry: Describe your plan for psychiatry staffing and ensuring that all performance specifications related to access to adult and child psychiatric consultation and direct services, in all ESP service components, are met 24/7/365.

CCBC will appoint Paul Weiss, MD as ESP Medical Director to oversee the rotation of on-call psychiatrists in Brockton and also in Taunton/Attleboro. Dr. Weiss is currently serving as the contracted Emergency Services Medical Director to the Brockton and Taunton/Attleboro ESPs operated by DMH. In the CCBC ESP for the Brockton catchment area, he will provide clinical supervision to the on-call psychiatrists, the nurse manager in the CCS, the ESP program director and the program manager for MCI. He will also sit in on weekly clinical rounds at the ESPs and CCS in the Brockton catchment area one morning per week. Other duties include acting as the clinical liaison to ED physicians and community primary care physicians and participation with the ED director in the regular meetings with the ED administrators.

CCBC has a rotating on-call system of psychiatrists who work for CCBC community-based programs, including the DMH-Operated ESPs. Each rotation lasts seven days. The doctors are required to respond to all calls from the ESP within 15 minutes, but CCBC expects them to respond within 60 seconds, almost 100% of the time. CCBC believes that the model of having a single doctor on-call in both catchment areas for case consultation will be a better use of limited resources across the two catchment areas. We believe that a consistent clinical approach across the two catchment areas will add value to the ESP program model that CCBC is proposing. As ESP medical director, Dr. Weiss will provide back up to the on-call rotation for both adults and children.

In an effort to increase the frequency of community-based mobile crisis interventions and use of alternatives to inpatient hospitalization, the medical director will chair a team to review and update the clinical criteria for diversion from the ED and from inpatient hospitalization. He will work with the Brockton and Good Samaritan Hospital staff to formalize a protocol for urgent psychopharmacology consultation for clients in the ED. The medical director will also be available for review of mobile requests.

The medical director will serve as the primary contact person in the ESP to provide a clinical resolution for clients who have remained in the ER or on a medical floor for more than 24 hours. An inherent strength of the CCBC system is the presence of psychiatric staff in various programs. The Board-certified child psychiatrist on-call function will be fulfilled by existing CCBC child psychiatrists. All psychiatrists meet MBHP credentialing criteria.

3.1.11 Strategies to Assess Risk

CCBC ESP staff will all be trained in completing core elements of a risk assessment, from the initial telephone contact to the completion of the intervention. Often the telephone contact comes from a family member or provider. The triage clinician asks critical questions about severity of symptoms, presence of weapons, recent use of alcohol or drugs, history of violence, and any immediate injuries or threats of injuries to the client or those in the immediate vicinity.

CCBC will develop a "*decision tree*" that their telephone triage and front-office staff will deploy to provide an initial risk assessment. This decision tree covers: signs of intoxication; any external reports of danger posed by the client to others or to him/herself; the current level of ideation of self-harm; the willingness of the client to engage with ESP staff on discussing his/her mental state; and to contract for safety and to transport him/herself safety to the location where the evaluation will be completed. The CCBC protocol also includes questions on the client's strengths and preferences.

In person, the ESP clinicians complete a standardized risk assessment form that covers the following: the client's current mental status; the treatment history; current collateral contacts; the CCBC clinical history and medical record review; the nature and seriousness of the presenting problems; and current stressors. For children, CCBC conducts a joint interview and separate interviews with the child and guardian based on the age of the child and the nature of the problem.

At each stage of the interview process, the CCBC clinician re-confirms the client's consent for treatment and their goals for the crisis intervention.

CCBC triage will go beyond the requirements of the RFR to consider with the client the possibility of the ESP clinician conducting the assessment in the client's community setting, even when the client is not willing. The ESP medical director will oversee the established protocols to work with local police and families to decide on a case-by-case basis if a mobile

visit is safe and warranted on a non-voluntary basis. The ESP will have the capacity to assign additional staff in these cases.

CCBC will continue to refine and centralize policies and procedures to guide the triage staff and ESP clinicians in decision-making on mobile crisis interventions that address the key risk and safety issues for community-based ESP services. The consistent application of these practices across the Southeast region will minimize risk for the clients and their families.

Strategies to Mitigate Risk

CCBC will deploy a host of strategies to mitigate risk during the course of a crisis intervention at the CBL. Most importantly, ESP staff, along with all other CCBC staff who work in the community, will carry electronic safety devices that alert supervisors, colleagues, and emergency responders, if necessary, if the employee is in any type of danger or requires back up or consultation. Currently CCBC has distributed over 250 of these devices (5 Star by Great Call) to CSP, CBFS, CBHI, and PACT staff.

There are three steps to mitigate safety risks in the ESP evaluation process: First, the ESP clinician will clarify the client's consent for treatment at each stage so that there is open and ongoing communication, even when the clinician determines that an involuntary intervention is required for safety reasons.

Second, when the clinical staff believe that the physical presence of the safety staff will provide stability and calm for an agitated client in a CBL, CCBC will deploy additional staff, including CPSs and FPs.

Third, in limited circumstances the hospital ED will be used due to the availability of security staff or local police may be asked to accompany clinical staff.

Finally, the ESP medical director or his designee will review all cases that are diverted from 24-hour care back to a community setting to ensure client safety as well as the safety of others.

3.2 Community-based location

3.2.1 Describe your ESPs proposed community-based location(s) including:

3.2.1.1 General description of the physical plant, include parking, signage, entryway, waiting areas, treatment areas, meeting space, and staff work areas.

The site is located at 157 Main Street, Brockton, on the corner of West Elm Street and Main Street, approximately two blocks west of City Hall. This central, downtown location is easily accessible to clients, families, and staff. This building previously housed the Brockton Neighborhood Health Center making it an ideal location for a behavioral health service. The offices are in close proximity to the District and Superior Courts, the Police Department, Brockton Hospital, and the new location of the Brockton Neighborhood Health Center.

The facility at 157 Main Street will be built out to include a reception area, three treatment offices for ESP evaluations, a conference room for group meetings of up to 10 participants, and three executive offices for the ESP program director, MCI program manager, and the ESP clinical supervisor. There is an adjacent parking lot for easy access of clients and collateral parties. The office will be accessible directly from the street with clear signage indicating the "Emergency Services Program of Community Counseling of Bristol County."

3.2.1.2 One Hundred Fifty Seven (157) Main Street is centrally located in downtown Brockton in close proximity to other mental health services, social services, the Mainspring Homeless shelter, the Brockton Neighborhood Health Center, and within 2 miles driving distance from Brockton Hospital.

3.2.1.3 One Hundred Fifty Seven (157) Main Street is located in the downtown Brockton community and thus qualifies as "being in the community."

3.2.1.3.1 Optional attachment: letters of support endorsing the selected location

3.2.1.4 The office is directly on the BAT Bus Line with a Brockton commuter rail stop nearby. It is a short drive for staff deployed to Good Samaritan Hospital.

3.2.1.5 CCBC will have warm and calming colors on the walls with recovery-oriented and strength-based posters complementing any artwork hanging on the walls. The message of the posters will communicate hope.

All staff will be trained in motivational interviewing, client engagement, and customer service skills to make sure the clients, their families, collateral providers and other parties are treated with respect, dignity, and the right to determine the course of their care and recovery to the maximum extent possible. Staff will repeatedly ensure that all persons who come to the ESP are oriented to the specific features of the program, beginning with initial contact. Staff will explain the steps to be taken during the ESP episode: initial information gathering, clinical assessment, plan of action developed with the client, and placement or discharge with identification of the necessary resources. The staff person will also provide an initial estimate for the length of time for each step of the ESP process. The client will also be made aware of the resources of the ESP, including an offer of support from a peer specialist or family partner to provide further explanation of the ESP process.

Staff will underscore the member's right to confidentiality and, while emphasizing the importance of talking to collateral providers, acknowledge the member's right to refuse the ESP to contact other parties and that only written permission will suffice once verbal permission is obtained.

3.2.1.6 CCBC staff will ensure that any client or family member coming to the Community-based location is fully oriented to the nature and purpose of the ESP and will repeat such clarifications as needed during the member's visit.

CCBC recognizes that emergency services staff will usually be encountering clients at moments of heightened vulnerability. To be effective, staff must rapidly engage the client, and develop rapport. A potential problem arises if the client decides that their ESP clinician is the only one that can help them. Staff will be very clear that their role is to support the client in achieving equilibrium and staff will communicate openness to the client's individual needs and preferences to address any acute psychiatric symptoms. On some occasions staff will need to set firm, but caring limits, particularly with that sub-set of clients that use the service and want ongoing support. A key in such situations is to use the techniques of motivational interviewing to align with clients on follow-up with community-based services. Indeed, linking the client to the appropriate community-based services is the primary goal of the ESP post-stabilization.

All staff will be trained to follow a standard protocol that results in a consistent message to the client: the ESP is for crisis intervention, stabilization and follow-up to the services that match the client's needs; that the client will be informed and have choice about that service; staff will keep lines of communication open to the client, his/her family as appropriate and for adults, when consent is given by the client, regarding next steps and available support for the client; and finally, that the client has access to a clinician, a peer specialist or family partner for the parent of a child, and that staff have access to consultation from a clinical supervisor, nurse and psychiatrist on-call if the need arises.

3.2.2 Describe how you shall utilize your community-based location(s) to achieve the goals of ESP and this procurement, including:

3.2.2.1 How the selected community-based location shall support the goal of diverting behavioral health utilization from the hospital EDs in the proposed catchment area

The CBL will be located in an accessible section of Brockton and will be open from 8:00 a.m. 8:00 p.m. Monday through Friday. The community-based location at 157 Main Street Brockton is located near public transportation and is accessible to the Brockton Hospital ED by walking or a short drive to promote diversions from the ED.

3.2.3 Staffing

3.2.3.1 Describe how the staffing in your community-based location shall be used flexibly to meet the needs on a daily basis, including integration with the adult CCS.

The CCBC Brockton ESP program will develop a model of flexible deployment of staff in the Brockton catchment area. CCBC is planning the features and benefits to assist MBHP in reducing reliance on the two EDs in Brockton, increasing mobile crisis interventions in the community and accessing a wider range of community-based alternatives to hospitalization. There are several highlights to the operation of this design that maximize flexibility and promote responsiveness to referral sources for crisis interventions:

- The co-location of the Brockton Community-Based Location (CBL) with the CCS at 157 Main Street, Brockton, will allow for staff from the CCS to assist staff assigned to the CBL during high call volume and demand for crisis interventions, staff shortages or acute client episodes within the community-based location. Similarly, staff in the CBL can assist staff in the CCS when there is higher than normal acuity or when clients' symptoms become more acute or disruptive in the CCS setting.
- Staff who are placed on site at either the Brockton or Good Samaritan hospital ED during evening shifts are not precluded from being re-assigned by the triage clinician to another site or to a mobile crisis intervention.
- The "hybrid" clinician position ensures additional staff during high volume periods of late afternoon early evening with a staff person who is available outside of the normal staff complement.
- CCS staff may be used for phone coverage, transportation to and from sites, and safety for office-based visits as part of de-escalation interventions.
- The peer specialists and family partners are available to accompany ESP clinicians for mobile visits.
- The administrative staff at both CBLs will be skilled at completing the administrative tasks that are often time-consuming in completing a crisis intervention. Their ability to communicate client status, verify insurance, respond to calls regarding a hospital search, and connect with collateral providers and family members, enables the ESP clinician to spend more face-to-face time with the client and the family completing the assessment and de-escalating the crisis.
- Eighty percent of the ESP clinicians will be cross-trained to work with children and families at the time of implementation. Within three months, 100% of ESP staff will be able to support the Youth Mobile Crisis Team.
- CCBC will draw upon its roster of experienced adult and child clinicians throughout the organization to assist in providing a rapid response during periods of unanticipated heavy demand.

3.2.3.2 Describe how you shall utilize Certified Peer Specialist staff in your ESP community-based location(s).

The CCBC ESP will work closely with the CPS to define and refine their role with the ESP. At the outset, however, we envision some key functions for the CPS:

- The CPS can provide peer support for clients who are especially withdrawn or perhaps somewhat agitated to assist the clinician in engagement and to provide reassurance during the period that the ESP and the client are awaiting a resolution to the intervention.
- The CPS can assist in the interview to help the clinician in understanding the client's symptoms and answers if the client is especially agitated. Sometimes an informal approach by the CPS may yield better results, and the client may share more if they know that the peer may have gone through similar struggles.
- The CPS can provide same day or next day follow-up to the client in assisting them with intake appointments, securing of basic necessities, applying for benefits, or attending local self-help programs.
- The CPS can accompany the ESP clinician on mobile crisis interventions as a "safety" staff person and to help in gathering information from family members or the referring provider.
- The CPS will run peer support groups in the CCS for interested clients to help them build coping skills and help them learn to access community resources, including 12-step recovery programs, housing, entitlements, and social supports.

3.3 Adult Mobile Crisis Intervention

3.3.1 Provide a brief program description that summarizes your planned Adult Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

3.3.1 CCBC's proposed model of operating the Brockton ESP will ensure a consistent application of MBHP performance specifications. This approach will enhance timely telephone triage, responsive program management, comprehensive clinical supervision, and access to risk management and quality improvement resources that will result in a higher quality of care, more efficient use of resources, and more timely achievement of MBHP goals. This structure will ensure a higher rate of mobile visits, higher rate of diversion from inpatient hospitalization and more timely responses to requests for ESP interventions.

Program Philosophy and Culture. The philosophy of CCBC's Brockton ESP is that rapid response to urgent care situations increases community-based interventions that lead to greater rates of diversionary disposition. Therefore ESP staff will quickly determine at the initial phone triage, the feasibility of an adult mobile crisis intervention through a telephone assessment by the experienced triage staff. They will work with the referral source to assess the utility of a mobile crisis intervention based on the client's willingness, the current risk and safety issues, the availability of family, friends or providers to assist, the need for police assistance, and any outstanding medical issues that would contraindicate a mobile visit. Other factors include CCBC's working familiarity with the referral source and the client's involvement with CCBC services including the client's prior ESP episodes both of which will be available to the Triage clinician through the CCBC Electronic Health Record (EHR) system. The ESP will also have access to any standing crisis plan with current providers, such as the CCBC Risk Management Team.

Service Delivery Model. When the telephone triage clinician decides on a mobile visit, s/he can immediately dispatch one of the available clinicians to the location. There will be a "*white board*" in the office that specifies the location and activity of all ESP clinicians on duty. The

triage clinician also has a roster of the hybrid clinicians and the other ESP relief clinicians who can be contacted if all of the clinicians on duty are involved in other crisis interventions. All master's level clinicians are available for mobile crisis interventions. With an adaptation of CCBC's EHR, CCBC will incorporate a computer tracking and scheduling system to monitor requests and response times throughout the two catchment areas.

Flow of Services. CCBC ESP managers and supervisors on-call will determine the support for the ESP clinician in the mobile setting. A mobile visit to a private home is likely to often involve two ESP staff. Visits to group homes, schools, local jails, and nursing homes will usually require only the ESP clinician, unless the client or family requests a CPS or FP.

3.3.2 Describe how you shall utilize bachelor's level staff and/or Certified Peer Specialists to support the adults utilizing these services and to assist the master's level clinicians in providing ESP services to adults in a mobile capacity.

3.3.2 The use of the BA and CPS staff for Mobile Crisis Interventions will follow the same protocol as the determination of mobile visit from the outset. For example, some clients prefer the presence of a CPS in their self-determined crisis plan. Other clients may prefer to have a person, who has similar experiences as the client in a crisis, accompany the clinician. CCBC also knows from experience that the BA-level or CPS can be a stabilizing influence on the client by taking time to explain to the client or sit with the client while a follow-up service is being located. The addition of these staff may also be preferred by the family member or referral source. The triage clinician will consider all of these factors in assigning a BA staff person or CPS to accompany the ESP clinician in a mobile crisis intervention. It is CCBC' goal to have the CPS fill the BA-level staff positions as well as the CPS positions. CPS staff can also be useful in keeping the family informed about the status of the assessment and answering their questions.

3.4 Adult Community Crisis Stabilization (CCS)

3.4.1 The goal of CCBC's CCS program is to stabilize clients experiencing a behavioral health crisis that might otherwise deteriorate to the point of needing hospitalization. The program shares several features with an inpatient setting: a multi-disciplinary team approach, a staff secure setting with around-the-clock presence of nursing and counseling staff, low client/staff ratios, a separate living environment that affords a respite from daily life, and the capacity to prescribe and monitor psychotropic medication.

Clients admitted to the CCS will participate in an organized program of individual and group counseling, peer support, medication management, education, and case management. The goal of the client's participation in the program is to enhance their existing strengths, stabilize their psychiatric symptoms, coordinate with existing supports in the community, and prepare the client for a timely return to their community setting. All clients will receive an initial bio-psychosocial assessment that includes an evaluation of current medications. Each day the assessment will be updated throughout the client's stay in CCS.

At the outset of the ESP intervention, the program philosophy will be to rule in all adults for admission to the CCS when the client requires a safe placement. This includes persons with active substance use issues and persons who present some risk to themselves or others. CCBC triage staff will then rule out admission to the CCS if the client's mental health requires the presence of skilled clinical staff around the clock, if a locked setting is required to prevent the client from harming him/herself or others, or if there are other medical conditions, including detoxification, that require monitoring by skilled medical staff around the clock.

CCBC will provide 24/7 awake staffing of the CCS with a minimum of one LPN and one BA counselor or safety worker on-site for all shifts. During the day and evening shifts, the clients will participate in structured activities, including medication education groups, self-help groups on building coping skills (facilitated by the CPS), discharge planning groups, and recreational activities. Staff will also provide case management activities with clients to assist them on making arrangements for follow-up care and other necessary resources such as housing, entitlements, court appearances, medical appointments, and accessing natural community supports.

Each client will have an assigned counselor who will oversee their participation in the program and work with the client on discharge planning, crisis planning, contacting current providers, arranging for intake appointments with new providers, and helping the client to identify and follow-up with holistic resources and natural community supports identified to be a part of the client's continued recovery.

The ESP psychiatrist will review and approve all admissions in consultation with the nurse manager and participate in medication evaluations as needed. The ESP psychiatrist will approve all CCS discharges.

3.4.2 Physical plant

3.4.2.1 General description of the adult CCS's space, including treatment areas, living space, meeting space, staff work areas, and parking

CCBC proposes to co-locate its ESP community location and CCS at 157 Main Street in Brockton. The site is located on the corner of West Elm Street and Main Street, approximately two blocks west of City Hall. This central, downtown location is easily accessible to clients, families, and staff. This building previously housed the Brockton Neighborhood Health Center, making it an ideal location for a behavioral health service.

The second floor space of this location, currently unoccupied, has up to 5,300 square feet available to fit the needs of the ESP and CCS. This space has a dedicated handicapped accessible entryway as well as elevator access from the street level. The parking lot leading to the primary entryway has 20 vehicle spaces, as well as additional street parking if necessary. The office suite meets all fire and safety code requirements. Every door and entryway meets ADA requirements and there are two handicapped bathrooms.

While this space will require some remodeling and build-out for the CCS component, there is more than adequate existing space for treatment areas, meeting space, and staff working areas. The current layout is conducive to all elements of the ESP and a modest redesign for the CCS. Directly upon entering the suite, there is a waiting room with a reception area for the program assistant to serve both the ESP and CCS. Given its previous use as a health center, there is plumbing available throughout the suite. The space is large enough to accommodate single bedrooms for the CCS, with potential expansion of capacity going forward.

The CCS will have six single-room occupancy bedrooms to accommodate six clients. There will be a communal living room for leisure and social group activities and all community meetings. There will also be two small counseling offices for individual meetings and one larger room for group meetings involving clients, families, and other providers to attend. The full-service kitchen will accommodate all residents.

3.4.2.2 How you shall establish a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support

The CCS will have warm, calming colors on the walls with posters that provide hope, encouragement, and examples of recovery for the residents. The rules of the program, client

rights, and daily schedule will also be prominently displayed so that clients are fully aware of their responsibilities and obligations in the program.

Staff will be trained in motivational interviewing, clarity of communication, and in holistic approaches to psychiatric interventions. The peer specialists will be part of the orientation for staff and will also be available to clients who seek informal communication to share any concerns about the program.

3.4.3 State your plan related to co-location of the adult CCS with the ESP community-based location

CCBC is actively engaged in discussing a lease arrangement with the owner of the property at 157 Main Street, Brockton to include a Community Crisis Stabilization program with six beds. The general floor is for street level entry with a greeting area. The main entrance is handicapped accessible and with over 5,000 square feet of buildable space has sufficient space for staff offices, interview rooms, medical records, and waiting area. The living space includes a kitchen, and bathrooms with shower. CCBC is negotiating a lease that will become effective upon notice of award with the schedule to permit necessary renovations before implementation date.

3.4.3.1 Describe the co-located or shared space relative to proximity, flow, and any space that shall be shared for functions of both the ESP and adult CCS.

The proposed CBL/CCS described above has a space configuration that provides ready access between the CCS and the CBL for maximum flexibility in staff deployment. The layout allows for both separation of the CBL and CCS, but also easy access between each service component. with the ESP component has a reception area, counseling rooms, administrative offices, and a conference room. The CCS area will have space for six beds, bathrooms, kitchen, living room, conference room, counseling rooms, and several offices for CCS staff.

CCBC will negotiate the lease at 157 Main Street, Brockton that will become effective upon notice of award, with the schedule to permit necessary renovations before implementation date.

3.4.3.2 The lease for co-location of the ESP will be in place at the time of the implementation of the contract.

3.4.3.3 N/A

3.4.4 Changes in CCS Capacity

CCBC proposes no changes to the capacity of the CCS in the Brockton catchment area.

3.4.5 What is your proposed communication plan between your adult CCS and your other ESP service components, particularly your ESP community-based location, for example, staffing, sharing resources, transfers, sharing clinical knowledge, risk management/safety planning, joint rounds, joint staff meetings, etc.?

3.4.5 CCBC is proposing to locate the telephone triage and community-based location for the Brockton catchment area in the same building as the CCS. The location of all staff on duty is listed on a white board. Triage clinicians have authority to call in additional clinicians and BA level staff when the need arises.

The ESP medical director and the nurse manager of the CCS will work collaboratively with other ESP staff in reviewing client records daily on all CCS clients. The nurse manager will conduct daily rounds for CCS clients. All CCS staff can follow-up with ESP clinicians who completed the initial ESP assessment if there are any questions. Psychiatrists will review each CCS client with the psychiatrist taking the next shift, as a warm clinical hand off.

At weekly staff meetings of all ESP staff, case presentations will be discussed to determine the appropriateness of members referred to CCS in line with risk management criteria around

safety. A portion of the staff meeting will include joint rounds to identify problem cases when a CCS admission could not be managed in the CCS and successful cases where CCS was an appropriate diversion.

On a monthly basis, the ESP program director will invite representatives from the Brockton Hospital and Good Samaritan EDs to participate in case reviews that involve members referred from EDs to CCS.

3.4.6 Describe your planned approach to utilize the full clinical potential of the adult CCS outlined in this RFR and the performance specifications. Address how shall you educate stakeholders of the capacity and acuity level of the adult CCS and how shall you make consumers, families, and other stakeholders feel comfortable using the adult CCS to treat those who present with a higher level of acuity.

3.4.6 Based on the experience of the CCBC-contracted psychiatrists providing clinical oversight to the DMH-operated CCS programs, CCBC will continue to build the culture within the ESP that the CCS can manage an increasingly challenging client. The CCBC psychiatrists who are contracted to work with the DMH-operated CCS's in Brockton and Taunton/Attleboro have developed a close working relationship with the nurse manager in charge of each CCS. Together they have developed a philosophical commitment to serving those most in need, and a track record of eliminating barriers to access. The first objective will be to review the clinical criteria and admission process to identify any obstacles to timely access. Among these are required medical clearances that may or may not be necessary. The second objective is to train all staff, including staff in the CBL, on the admission criteria, admission process and approval of admissions.

As a new provider for ESP and CCS services in the Brockton catchment area, CCBC recognizes that much work with stakeholders will be necessary to build an acceptance of the full capacity of the CCS, especially one that is located in the community setting of downtown Brockton. There are several steps that CCBC will take to demonstrate the capacity of the CCS: First, the admission criteria and steps to admission process will be distributed to all clinical referral sources, including hospital EDs, Brockton Neighborhood Health Center, mental health centers, CBFS and PACT providers in Brockton, DMH case management staff, and local ambulance companies as well as law enforcement officials. The second step will be face-to-face meetings with examples of recent referrals that were admitted to the CCS to provide a context for the referral sources as well as examples of clients. The other step will be to host a series of open houses at the CCS to encourage stakeholders to view the physical setting and meet the direct care staff.

Once the CCS has begun operating, the ESP program director will assign staff to work as ESP clinician "*ambassadors*" to community programs such as nursing homes, group residences, shelters, and community support programs whose clientele can most benefit from the CCS as an alternative to hospitalization. CCBC's social marketing efforts will tout the benefits and the capacity of the CCS to other providers as well as to ED medical staff and police. The ESP will also hold informal "open houses" for community stakeholders to visit both the Central Triage and the CCS.

3.5 Mobile Crisis Intervention (MCI) Response Section

(Note: An incomplete or unsatisfactory response to this element could exclude a bidder's proposal from consideration.)

3.5.1 Statement of intention:

X The bidder intends to directly operate the Mobile Crisis Intervention component of the ESP and shall demonstrate competency in the section that follows.

N/A The ESP intends to enter into a subcontract arrangement with another entity that meets the requirements of subcontractors outlined in Section V.C. of this RFR.

3.5.2 CCBC believes that we are well positioned to exceed the MBHP Performance Specifications of the MCI Program in the Brockton catchment area because of the following:

1. CCBC has two years of experience as the contractor for MCI services to the DMH-operated MCI Team.
2. CCBC has 12 years of experience as the contractor for Emergency Psychiatric Services with the DMH-operated ESP Team in Brockton.
3. CCBC has established leadership as the CSA provider for other children's behavioral health providers and other children's stakeholders in the Taunton/Attleboro area. This foundation of leadership, collaboration, and skill at establishing the Wraparound model of care with a variety of stakeholders in the Taunton/Attleboro catchment area will be implemented in the Brockton area in collaboration with the Brockton CSA and other CBHI providers and children's stakeholders in that area. CCBC's letter of support from the CSA provider, Brockton Area Multi-Services, Inc. (BAMSI) confirms CCBC's qualifications in Brockton. CCBC is best positioned to deliver MCI with the highest fidelity to the wraparound model of care.
4. CCBC's Taunton/Attleboro CSA is the lead behavioral health provider for Bristol County's Juvenile Justice Behavioral Health Alternative Path Program (JJ-BHAPP).
5. The operation of the CSA and other CBHI services is continuously being improved through a robust quality improvement process based on feedback from families and standardized measures of wraparound fidelity. This Continuous Quality Improvement (CQI) process will include the Brockton MCI program.
6. CCBC has a solid foundation in Taunton/Attleboro as a provider of Child Outpatient mental health services, CBHI services such as In-Home Therapy and Therapeutic Mentoring, as well as the established Community Service Agency (CSA) for the Taunton/Attleboro area.
7. CCBC is the Runaway Assistance Program (RAP) lead for all of the Southeastern Area for DCF that includes the Brockton area.
8. CCBC has a community orientation in the Brockton catchment area through our PACT and CSP programs.

3.5.3 Further demonstrate your organization's readiness to provide Mobile Crisis Intervention by attaching the following documents (as many as are available and applicable to your organization) in order to demonstrate meeting the criteria delineated in Section V.B. of this RFR:

3.5.3.1 Below are examples of CCBC's experience with key measures of competence for an MCI Program:

- CCBC serves 3,000 children annually in our outpatient mental health clinics.
- CCBC serves 900 children annually in our full spectrum of CBHI Services: Intensive Care Coordination, Family Support and Training, In-Home Therapy and Therapeutic Mentoring.
- CCBC employs 10 family partners in its CBHI programs. One of these family partners also works for the DMH-operated ESPs as one of the family partners.
- CCBC's CSA is fully compliant with MassHealth CBHI performance specifications in the use of the Strength-Needs-Cultural Discovery Assessment Form, in developing Crisis Management Plans with families, scoring on the Wraparound Fidelity Index (WFI) and Team Observation Measure (TOM) measures, and Family Satisfaction survey results on families being included in service planning.
- CCBC's CSA meets twice a year with the MCE network managers, a proxy for compliance with existing standards of care related to access, quality, and outcome.

3.5.3.2 CCBC is fully compliant in training all staff on the Principles of Wraparound Systems of Care. Staff receive ongoing coaching and training to maintain and improve skills.

See Attachment 3.5.3.2 for evidence from the Wraparound manual indicating CCBH's compliance.

3.5.3.3 Evidence of working with Family and Youth.

See Attachment 3.5.3.3 on FY 2014 Report on Family Satisfaction Survey and key findings from FY 2015 survey.

3.5.3.4 Policies and Procedures and/or Clinical Protocols.

See Attachment 3.5.3.4

3.5.3.5 Outcomes Data: CCBC's CSA participates in the measurement of the WFI, and the TOM with other CSA's.

See the WFI and TOM Reports in Attachment 3.5.3.5.

The scores are tallied annually and CCBC uses the findings to design program improvements to better serve children and families.

See Attachment 3.5.3.5 on FY 2014 Report on Family Satisfaction Survey and key findings from FY 2015 survey.

3.5.3.6 Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels in providing behavioral health services to children, adolescents, and their families. Evidence may include accreditation reports that speak to your work with youth and families and in-service training schedules or curriculums addressing the assessment and treatment of youth and families.

CCBC's CSA provides a credentialing report to the MCE's on the staff hired as intensive care coordinators and family partners.

The agency operates three licensed outpatient sites licensed by DPH that serve children and families.

See Attachment 3.5.3.6 for the Wraparound Facilitator Checklist.

3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention

3.5.3.7.1 ***See Attachment 3.5.3.7.1***
3.5.3.7.2 ***See Attachment 3.5.3.7.2***

Job descriptions of any identified staff members who would be staffing the Mobile Crisis Intervention service in any capacity, including the Mobile Crisis Intervention program manager, child psychiatric clinicians, child-trained supervisors, child-trained clinicians, paraprofessionals and/or family partners.

3.5.3.8 Experience of integrating youth and family voice in organization governance. Evidence may include names and length of service of those currently on advisory boards.

One member of CCBC's Board of Directors has a child with serious emotional disturbance bringing that experience and voice to organizational governance. Also, the CCBC CSA's Systems of Care Committee convenes monthly meetings that are open to all children's advocates and stakeholders in the Taunton/Attleboro catchment area. CCBC's family partners and CSA and IHT family members in care attend the monthly statewide PPAL meetings.

The CSA director is a member of the DCF Children and Family Area Board for Children. The goal of the meeting is to provide support to DCF foster parents, help children graduating from Foster Care into independent living and support DCF's mission overall. The CSA director is also on the board of Associates for Human Services' Early Intervention Transition Committee for children transitioning from Early Intervention to public school. CSA has also conducted focus groups comprised of parents and guardians of children enrolled in the CSA to solicit their input into program development.

3.5.3.9 The CCBC CSA has worked with the DYS, DCF and DMH residential providers when members from their CSA are receiving 24-hour care in one of these programs. The CSA has also accepted referrals of children and families from the Brockton catchment area when there is a temporary backlog in the Brockton CSA. When doing so the CSA has worked along with the Brockton School Department, local IHT, and In Home Behavioral services.

3.5.3.10 Membership in child advocacy and/or child-focused trade organizations

CCBC is a member of the following local and statewide child advocacy and trade organizations:

- Parent Professional Advocacy League (PPAL);
- The Department of Children and Families' Area Advisory Committee;
- The Association for Behavioral Health (ABH)'s CBHI committee and ABH's Child Policy Committee;
- CCBC attends Statewide CSA Meetings, Southeast CSA meetings and the CSA statewide Coaching meetings; and
- Language Access Committee in Taunton/Attleboro Area, facilitated by Associates for Human Services

3.5.4 Mobile Crisis Intervention

3.5.4.1 Provide a brief program description that summarizes your planned Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.
Describe how you will provide a bi-disciplinary (clinician and family partner) intervention to engage and address the treatment needs of the child while also engaging, and supporting the experiences of the parent(s) whose child is in crisis.

Program Description. CCBC will implement the Mobile Crisis Intervention program in the Brockton catchment area to be fully compliant with the ESP Performance Specifications and consistent with the Principles of the Wraparound model of care. CCBC's program philosophy underlying MCI services are embodied in the Principles of Wraparound Services. CCBC will be committed to providing 70% of the services at a minimum in the community-based settings, such as schools, homes, day care programs, after-school programs, and group homes and shelters. All clients presenting for Mobile Crisis Intervention will be evaluated by the clinician who is child-competent and experienced with children and families.

MCI staff will be fully trained in the Wraparound model of care to provide a strength-based approach to children with SED and to their families. Their approach to family engagement and empowerment and the child's resiliency will increase the use of the full continuum of community-based alternatives in the Brockton catchment area to which families and children can receive support as diversions and safe alternatives to 24-hour care. The MCI clinician will work in partnership with family partners to engage the whole family, complete a thorough bio-psychosocial assessment that includes family preferences, resources, and natural supports, and work in partnership with the family to determine the next steps for supportive services. The CCBC MCI will have the capacity to support the family throughout the crisis up to seven days of mobile crisis intervention as needed by the family to stabilize the presenting crisis and facilitate a smooth transition to other CBHI services, as needed.

All staff will be capable of providing MCI in community settings throughout the Brockton catchment area.

The MCI staff will have access to two board-certified child psychiatrists, Diane Press, M.D. and Gabriella Velcea, M.D. to discuss clinical dispositions and to resolve complex clinical issues, especially as they arise with children in DCF or DYS custody. The goal of the intervention is to assure the safety and comprehensive clinical management of children in crisis.

A key component of MCI is the initial and ongoing support for the family, provided by both the ESP clinician and the family partner. Families will receive ongoing support as the disposition is being implemented. The team approach can be especially valuable when families are waiting in the Hospital Emergency Department where the atmosphere can be chaotic and stressful.

CCBC recognizes that the resolution of the presenting problem is only one part of the full crisis intervention. The Wraparound approach includes assistance to the family in identifying natural community supports and resources to give the family additional strengths to support the child in crisis. The support for the child and family also includes a seamless transition to other CBHI services on a timely basis.

3.5.4.2 The CCBC MCI program manager will have a full complement of full-time, part-time and on-call clinical and family partner staff for the Brockton ESP. In addition, there will be a Centralized Triage and clinician assignment capacity that will afford the Brockton MCI program additional resources from the Taunton/Attleboro catchment area to address

fluctuating demand in the Brockton area, especially at Brockton Hospital which has been one of the higher volume EDs in the state in recent years. CCBC can draw upon the current roster of MCI staff that are contracted with DMH as well as the family partners who work in CCBC's CBHI programs. CCBC also has a full complement of outpatient clinicians who are child competent.

In addition, CCBC will train all ESP clinicians to be competent in completing child clinical evaluations. The additional capacity will help CCBC to address fluctuating demand for children's evaluations. CCBC has had success with hiring parents of children with SED as family partners once the parent has completed their involvement with the CSA.

3.5.4.3 CCBC has learned from our experience in the Wraparound Model of care that the needs of children with SED can vary from hour to hour and day to day. The Wraparound Model provides a foundation to work with the family to assess their needs, mobilize their strengths, and provide ongoing support as needed during the crisis. Such an approach will be smoothly adapted to the MCI model of intervention with families up, to seven days as needed.

There are several steps to take during the initial intervention to assure access to the seven-day intervention. First the MCI clinician will assess the child's safety and mental status to insure that the symptoms of the serious emotional disturbance can be managed in a home setting. This assessment will be reviewed with the clinical supervisor, ESP program director or consulting child psychiatrist. Second, the family partner will orient the caretaker to the nature of the MCI visit and outline options for them that include placement outside the home, referral to community-based services and ongoing support from the MCI Team that includes both clinical staff and family partners to help stabilize the child. Third, when the clinical assessment is completed, the MCI Team will work with the caretaker to outline the options and help the caretaker to choose the best option up to and including a seven-day intervention. Finally, the MCI Team will work with the child and family to identify the follow-up services needed post stabilization and identify the steps the family needs to take to secure those resources.

During this time, CCBC will engage other CBHI providers including In-Home Therapy as a transition from the crisis intervention episode to ongoing treatment. The culture in CCBC's CBHI service array involves ongoing flexibility to meet family needs and recognition of the non-linear nature of serious emotional disturbance and family resiliency in crisis.

If CBHI services are already in place for the family, MCI can be accessed to meet additional needs identified in the mobile crisis intervention that fall outside the hours that the CSA and In-Home Therapy are being provided. CCBC has a demonstrated track record to meeting access standards for CSA's without a waiting list. This practice will be extended to the operation of the MCI's ongoing reporting to CCBC's senior leadership.

During the course of the intervention the MCI Team will review the child and family's status with CCBC's ESP clinical leadership to ensure that client safety is being maintained and that progress is being made to stability and follow-up supports.

3.5.5 CCBC has established a culture of linkage to CBHI services through its experience convening Systems of Care meetings in the Taunton/Attleboro catchment area. In Brockton, CCBC MCI staff will actively seek out Brockton Area Multi Services, Inc. (BAMSI), the CSA provider in Brockton, to participate in their Systems of Care meeting. The CCBC MCI will also convene smaller meetings of CBHI providers and other stakeholders to develop safety plans for children at risk of, or following a crisis intervention. CCBC will utilize these linkages to enhance family voice and choice in the establishment of these safety plans that are designed to keep the child at home, support the family, and engage them in the supportive care of their child.

Our CSA has already established working relationships with residential programs operated by DCF, DYS, BSAS and DMH in the Brockton catchment area. The CSA program director has a working relationship with the DCF Area Office that oversees both the Brockton and Taunton/Attleboro areas.

Another strategy to ensure linkages with other CBHI providers is to enlist the support of the Managed Care Entities who can help the MCI staff access CBHI service providers, outpatient providers and specialty providers to support the family. CCBC recognizes the MCE responsibility to ensure timely access for their members, especially members who are in crisis.

3.6 Runaway Assistance Program (RAP)

CCBC is the designated Runaway Assistance Program (RAP) for the four state operated Emergency Services teams in the Southeast Region, as one component of its Emergency Services contract with DMH. This service provides assistance to police officers who are dealing with runaways during the hours the juvenile courts in the Southeast region of DCF are closed. The service operates Monday thru Friday 4:30pm to 8:30amand weekends from Friday 4:30pm–Monday 8:30 am, the times that the courts are not open to respond to these situations. CCBC on-call staff are prepared to respond to conduct a face-to-face assessment of any child age 17 and under who is brought to the ESP community site within one hour of notification.

3.6.1. Describe your experience in collaborating with local police departments, court clinics and DCF relative to youth served by your agency.

CCBC has a long history of collaboration with local police departments, court clinics and DCF youth. CCBC was a leading partner in the design and delivery of the Community Crisis Intervention Training program through a contract with the Taunton Police Department. When a CSA or IHT client is involved or potentially involved with the police, the staff will request that the police assign an officer who has been through the CCIT program to provide a more sensitive approach to the child and family. CCBC has also shared crisis safety plans with the police to prevent escalation of crisis situations when law enforcement is involved. The police are invited to the CCBC Systems of Care meetings in the Taunton/Attleboro area. The CCBC CSA Systems of Care has regular collaboration and attendance from the court clinics, DYS, DMH, DCF and Juvenile Justice Partners.

CCBC has been designated as the first CSA to participate in the Juvenile Justice Diversion Program in Bristol County, set to begin in the fall, 2015. Court Clinic personnel are invited to attend the Systems of Care meetings hosted by the CCBC CSA.

As stated above, CCBC serves on DCF's Advisory Committee for the Taunton/Attleboro catchment area and invites DCF personnel to attend the monthly CSA Systems of Care meeting.

4. Additional response requirements, if applicable to bidder (considered but not scored)

4.1 Hospitals as bidders

4.1.1 N/A

4.2 Bidders submitting responses for multiple catchment areas

4.2.1 Community Counseling of Bristol County is pleased to submit a proposal for a regional approach covering both the Brockton and Taunton/Attleboro catchment areas to operate the Emergency Services Program for MBHP. We believe that this model offers superior value to clients, their families, MBHP and the important stakeholders through the creation of a regional network, which provides a more efficient, flexible, effective, uniform, and integrated ESP program of the highest quality.

The regional ESP system will be overseen by a program manager who will supervise both the Brockton ESP program director and the Taunton/Attleboro ESP program director. The two combined ESP sites will also benefit from the expertise of a medical director who has been associated with the two ESPs for 5 years. One psychiatrist will be on-call for both sites, substantially reducing the cost of on-call psychiatry. The expanded roster of ESP staff will be available in both catchment areas through CCBC's Centralized Triage, providing greater flexibility to respond to fluctuations in demand. The regional staffing will include a large enough pool of workers for CCBC to recruit specialist staff for the following populations: Hispanics, Cape Verdeans, and persons with developmental disabilities. In addition this model will allow for a team of certified peer specialists and family partners to become integrated into the ESP model and offer greater support to one another. Similarly, continuous quality improvement, risk management and billing functions and cost would be spread over a longer base, reducing total cost.

4.2.2. As the operator of two ESPs in the Southeast region, CCBC will bring a number of strengths that will enhance the goals of the ESP in both operation and in better matching services to the needs of the members. First, CCBC will be able to extend the culture of community-based recovery and collaboration with other stakeholders to Brockton, where CCBC already provides care in its CSP, PACT and psychiatric emergency services. Second, CCBC will have a wider pool of ESP clinicians, peer specialists and family partners to draw upon for the Brockton catchment area. As the largest behavioral health provider in the Taunton area, CCBC has refined the skill at recruitment and retention of both clinicians and non-clinical staff. Third, CCBC's community orientation towards strength-based, solution-focused, and client-centered interventions will reduce the volume of clients going to EDs in both areas and will access untapped community resources for clients to access to prevent exacerbation of the mental health conditions. Finally, the administrative efficiencies of a combined oversight will reduce the financial exposure at the startup of the program.

While CCBC believes certain efficiencies are achieved with an ESP serving the combined Taunton/Attleboro and Brockton areas this proposal is not contingent upon a combined service area. This proposal for the Brockton ESP may be considered a stand-alone proposal.

1.9.2 Quality Management Plan

ESP RFR Attachment 1.9.2

Community Counseling of Bristol County, Inc.

Policy and Procedure

Title: **Quality Management Plan** Policy Number: VII-01

Effective Date: August 5, 2005

Page: 1 of 7

Reviewed/Revised Dates:

8/2/05, 2/20/14, 5/19/14, 2/10/15, 3/3/15, 3/10/15, 3/18/15, 4/2/15, 6/2/15, 8/26/15

GOVERNANCE AND STRUCTURE

STATEMENT OF POLICY:

In order to fulfill the mission of the Agency, Community Counseling of Bristol County, Inc. is committed to a comprehensive quality management, which includes continuous quality improvement and regular program evaluation.

The purpose of this plan is to ensure that reliable and valid data are gathered, reviewed, analyzed, and utilized in correcting problems, enhancing the quality of the Agency's services, and obtaining and properly managing the human, financial, physical, and community resources, so that the services provided to individuals and families served meets the highest standards of ethics, quality, and cost effectiveness. All services and administrative operations of the Agency are included.

The Agency's Quality Management processes include data collection, review, and management actions that are sufficiently frequent for timely corrections or improvements. The processes are inclusive, involving individuals served, staff, and community and Board representatives. The processes are functionally integrated in ongoing management activities – identifying strengths, weaknesses, and areas for development, and tracking the implementation and success of management actions designed to improve program outcomes, solve problems, and enhance the quality of services.

Quality management includes three essential components. The first, and most important, is an organizational commitment to quality care and to the continuous improvement of that care. Beyond this commitment, the two additional essential components, organizational structures and processes, are required to continuously monitor, measure, and evaluate the care provided. The following describes the organizational structures and processes in place at Community Counseling of Bristol County, Inc. (CCBC) designed to carry out the quality management with respect to the Agency's management and programmatic performance.

1. **CCBC has a governing body, which functions with overall responsibility for the Agency's operations.**

CCBC's Board of Directors is the governing body for the Agency, with overall responsibility for the Agency's operation. The Board meets on a bi-monthly basis. Committees of the Board, Finance Committee, meet monthly or with greater frequency as needed. CCBC's President has regular contact with the Chair of the Board of Directors to update him on Agency services, finances, personnel and related issues. The Agency's President is an ex-officio, non-voting member of the Board of Directors attending all meetings of

the Board of Directors. Other management staff attends meetings of the Board of Directors as requested. At each meeting of the Board of Directors, the President reports to the Board on the organization's finances, services, human resources, regulatory issues and other matters of importance to the Corporation.

At least one member of the Board of Directors participates as a member of the Patient Care Assessment Committee (PCA) and reports to the Board on a quarterly basis. The Patient Care Assessment Committee is a primary mechanism by which the Board of Directors monitors and evaluates the services of the organization. The Agency's PCA Plan is approved by the Massachusetts Board of Registration in Medicine The PCA Committee is comprised of the Chief Operations Officer, the Medical Director, the Vice President of Integrated Care, the Vice President of Adult Outpatient Services, the Vice President of, Child & Family Services, the Vice President of Community Treatment and Rehabilitation, the Vice President of Housing and Special Initiatives, Quality Management and Compliance Coordinator, and other staff as assigned.

The PCA Committee regularly reviews the activities of the Risk Management Committee (RMC), the Safety Committee, and the Human Rights Committee. The Committee also reviews the results of any and all external reviews, including: all investigations, contract performance reviews, compliance reviews and licensing reviews. The Committee also reviews the results of any internal audits and regularly reviews client outcome data and client satisfaction surveys.

The Agency maintains an ongoing program to assure that processes are in place to assess and maintain compliance with regulatory requirements and contractual obligations provides mechanisms for staff reporting and regularly performs tests of compliance in areas identified as critical or difficult from a regulatory compliance perspective or when prior compliance has been a problem.

2. CCBC maintains up-to-date written descriptions of the administrative structure and lines of authority of the Agency.

CCBC maintains an up to date Table of Organization. The Board of Directors is the appointing authority for the positions of President and Medical Director. The President appoints all other staff. The organizational chart is reviewed at a minimum of once a year, but also at each occasion as a new program or service is added to the Agency's continuum of care.

The Leadership Team for the Agency meets on a weekly basis, and is comprised of the President, the Chief Financial Officer, Chief Operating Officer, Vice President of Adult Outpatient Services, Vice President of Child and Family Services, Vice President of Community Treatment and Rehabilitation Vice President of Integrated Care, Vice President of Housing and Special Initiatives, Facilities Manager, and Human Resources Coordinator. Other management staff, including Program Directors, meets with the Leadership Team on a monthly basis. The purpose of this meeting is to assure good communication, disseminate information, and develop and review organizational policies and procedures. Program Coordinators and others are invited for specific projects and discussions. Minutes are kept of each meeting. The Leadership Team is charged with responsibility for all aspects of management of the Agency, including, but not limited to developing and monitoring program budgets, meeting licensing requirements, human resource management, identifying operational problems and solutions, reviewing consumer access and service issues and participating in quality management activities.

3. Assessment of Program Quality and Performance.

The Quality Management Plan is designed to insure that sufficient monitoring and evaluation procedures are in place to assess program quality, measure program performance against stated goals and improve client outcomes and overall program quality.

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Components of the Quality Management Plan include:

1. **Standards and Performance Evaluation:**

   (a) Evidence Based and Evidence Informed Practices: The organization is committed to meeting or exceeding the expectations of our stakeholders. Stakeholders include clients, purchasers, staff, regulatory agents, and community members. Meeting or exceeding the expectation of stakeholders is closely associated with providing care and treatment based upon the best science and treatment approaches available. In behavioral health care the best science available is incorporated into what is known as evidenced-based or evidence informed practices. Whenever possible the organization embraces evidenced based practices in the delivery of care and treatment. Current evidence based practices include Dialectical Behavior Therapy in Day Treatment and CBFS, Motivational Interviewing in Outpatient, and Illness Management and Recovery (IMR) in Day Treatment and CBFS. The PACT and CSA programs are also held to tight industry fidelity standards.

   (b) Client Outcome Data: On no less than an annual basis, all programs establish appropriate methods for assessing and measuring client outcomes both on a client specific basis and on an overall program basis. These data will serve as a critical component of program evaluation and the basis for initiatives to improve client outcomes.

   (c) Risk Management Data: All agency incidents, as described later in this document, are recorded, categorized and aggregated in order to analyze trends and inform performance improvement.

   (d) Continuous Quality Improvement: Each year opportunities for quality improvement are identified. With input from its constituencies, objectives are set for major programs. Each program also identifies responsible parties, resources, processes, and timetables needed for implementing the plan. In establishing goals and objectives for quality improvement, the Agency obtains input from, and considers the interests of clients and their families, referral and funding sources, other community representatives, staff, and the governing body.

   Objectives are generally derived from the following categories:

   1. **Service outcomes, indicating effectiveness and/or cost-effectiveness of services. Examples: independence, as measured by decreases in required personal assistance and supervision for clients living in group living environment.**

   2. **Service progress, indicating the progress of clients served in their course of program activities. Examples: the percentage of individual service plan objectives achieved vs. set for clients with severe and persistent mental illness.**

   3. **Service processes, indicating the amounts, utilization, timeliness, appropriateness, and quality of services, and their documentation, as measured by routine service and/or management data systems, and by special audit processes. Special systems to monitor the protection of client rights and client choice are also measured. Examples; the average time between referral and evaluation by a prescribing clinician; the percent of individual service plans updated as specified by timeliness standards; the number of serious human rights complaints filed in a given time period.**

4. **Management of human, financial, physical, and community resources. Examples: the percentage of staff turnover in a given time period; the average time required to complete a repair or maintenance task.**

5. **Stakeholder surveys for all areas of operation, including service outcomes, progress, and processes, and surveys of staff, referral source, funder, and customer/community satisfaction with program services and management. Example: customer satisfaction ratings on several dimensions of access, service, and outcome.**

6. **Client Satisfaction Surveys are conducted regularly in all programs providing an important information and direction from agency clients regarding the appropriateness and effectiveness of the programs and services and ideas on how to improve the quality of the service.**

(e) A common approach for guiding quality efforts is the *PDCA* Model, referring to the stages of *Plan, Do, Check, Act* as described below.

Plan: **Identify the area of focus, process, or element that will be concentrated upon. Having past data will be important here for more longitudinal efforts. Develop measurement standards, quality measures to be employed, and indicators used in the *Do* stage. Current baseline data will be required for comparison in the *Check* stage.**

Do: **Implement the designs created in the *Plan* stage. Collect data as designed.**

Check: **Examine the data collected. Assess the data's accuracy, validity, and reliability. Is the information meaningful and informative? Was the goal(s) achieved? From a PDCA stand point, what worked well and what could be improved upon for future cycles?**

Act: **Take action on the information. Make adjustments for future planning. Start the *PDCA* cycle over again.**

2. <u>Human Resource Management</u>

(a) <u>Credentialing and Privileging</u>: A system of credentialing and privileging for staff licensed at the independent level is in place and is reviewed and updated by the Professional Services Review Committee (PSRC). The PSRC is comprised of the President, Chief Operating Officer, Medical Director, and Vice Presidents. Credentialing includes verification of academic degrees, licensure, and previous employment experience. References are required and documented. Staff are privileged by the Board of Directors subsequent to credentialing and review by the PSRC.

(b) <u>Training</u>: <u>All clinical and direct care staff positions will have an identified set of core competencies described as part of the job description. The job description will also indicate how the core competencies are to be evaluated. In most instances, there will be a specific set of training requirements which must be complete in order to satisfy that these core competencies have been evaluated and achieved. Each program manager will be responsible for establishing these training requirements and documenting that they have been fulfilled. All professional</u>

licenses are updated periodically, generally every two years. All licensed staff is required to have a current license on file with the Human Resources office.

(c) **Supervision**: All direct care and clinical staff will receive regular supervision. Individual clinical supervision for staff providing outpatient services occurs on a regularly scheduled basis in accordance with Department of Public Health regulations. Clinical supervision is documented by the supervisor. The focus of supervision is to review the quality and clinical appropriateness of care.

(d) **Staff Evaluation**: Newly hired employees will receive an evaluation at the end of three months. This review will be documented. Subsequent to the first three months of employment, employee evaluations will be conducted each year. Staff who exhibit performance difficulties, may receive an evaluation and/or performance improvement plan at any time during his/her employment. New staff may be evaluated prior to their one year anniversary. Also, any staff person who is on some disciplinary status will have an evaluation at a timeline indicated in the written notice.

(e) **Continuing Education**: The Agency has **an organized training initiative** in which managers, supervisors and line staff from the continuum of services participates. The Agency offers a staff training and education program that focuses upon incorporating evidenced-based practices into the Agency's practices at all levels. Managers and supervisors review the professional literature to identify evidenced based practices and to design relevant training curriculum, which is required of CCBC employees.

(f) CCBC has an online learning system that has the capacity to support, advance, and track agency and programmatic training initiatives. The system includes over 600 offerings and can be used to create program-specific courses and individual specific curricula.

(g) The Agency offers **staff training opportunities** to access workshops offered outside CCBC. When resources permit, financial assistance towards the cost of the workshop is provided.

All staff are expected to maintain any and all relevant licenses for which they are eligible and secure all necessary continuing education credits to do so.

3. **Risk Management and Safety**

(a) **Risk Management Committee** was developed to address the needs of CCBC consumers, staff and the community at large with respect to insuring the operation of the Agency's program in a manner that promotes the safety, well-being and dignity. This Committee is chaired by the President and includes the Vice President of Adult Outpatient Services, Chief Operations Officer, the Vice President of Community Rehabilitation Services Vice President of Community Treatment and Rehabilitation, Vice President of Housing and Special Initiatives, Medical Director, Vice President of Integrated Care, the Vice President of Child and Family Services, and the Quality Management and Compliance Coordinator..

The responsibility of the Risk Management Committee is to provide timely and ongoing review of those incidents, events and situations that present the potential for significant risk to the safety or wellbeing of clients, staff or others and to make recommendations as to clinical, supervisory and administrative procedures and protocols to the governing body, Patient Care Assessment Committee, Leadership Committee, and other committees as appropriate. A file of all incidents

is maintained. All incidents are reviewed and action taken as appropriate. All action taken by the Committee is documented in writing.

The Risk Management Committee reviews the following:

Major Incidents As Defined By the Board of Registration in Medicine 243 CMR 3.08:

1. Maternal deaths that are related to delivery.
2. Death in the course of, or resulting from, elective ambulatory procedures.
3. Any invasive diagnostic procedure or surgical intervention performed on the wrong organ, extremity or body part.
4. All deaths or major or permanent impairments of bodily functions (other than those reported above) that are not ordinarily expected as a result of the patient's condition on presentation).

Critical Incidents: With respect to all clients deemed eligible and receiving services under contract between CCBC and the Department of Mental Health, any events defined as a Critical Incident by DMH Critical Incident Reporting Protocol effective October 1, 2012 and any subsequent reviews.

Serious Incidents (Department Of Public Health):
Serious Incidents as defined by the Department of Public Health (105 CMR 140.307) which includes any of the following which occur **on the Agency's premises**:

1. Fire,
2. Suicide,
3. Serious criminal acts; or
4. Pending or actual strike action by employees.

Risk Management Screening and Monitoring Events:
Such other events and situations determined by the **CCBC RISK COMMITTEE** not limited to but including:

1. Any situation which a supervisor or a clinician requests a risk assessment or review.
2. All client deaths including, but not restricted to, medical/legal deaths.
3. All incidents of any suicide attempt that results in medical treatment or results in significant injury, or could have resulted in significant injury or impairment.
4. All requests for commitment under the provision of Section 12E of M-G-L CH 123, issued by any member of our clinical staff (psychiatrists, psychologists and clinical nurse specialists).
5. Any alleged sexual assault by a client or upon a client at any agency facility.
6. Any injury to a client or to a staff member at an Agency facility.
7. Any injury to a staff member while on duty.
8. Any violence by a client directed toward another client or staff. This includes threats and acts of intimidation.
9. Situation which gives rise to a "duty to warn" third parties of the likelihood or threat of aggression by a client or if a client utters any threat to staff, clients or others.
10. Any mandated reporting required of providers under Massachusetts General Laws pertaining to the neglect of children (51A), the abuse or neglect of disabled persons per the Disabled Person's Protection Commission, or the abuse or neglect of elderly persons.
11. Any reported or alleged human rights complaint.

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12. Any written complaint filed by a client, parent or guardian of a client with regard to their care or the care of their child for whom they have custody, or the individual for whom they are guardian, or ay complaint that the Committee chooses to review.
13. Any medication occurrence.
14. Any act of violence against a staff member of the agency, including assault, assault and battery, threats, intimidation or coercion that occurs during the course of their service.
15. Any act of violence against a client of the agency in the course of their receiving care provided by the agency.

1. **Safety Committee**: The organization maintains a Safety Committee for the purpose of ensuring that services are provided in a manner that promotes safety for clients, staff, and the community. The Safety Committee reviews its activities with the Board of Directors on a regular basis and makes recommendations to the Board and management with respect to the safety of clients and staff. The Safety Committee reviews the Workplace Violence Prevention Plan at least annually and makes recommendations to management as to changes in the Plan.

2. **Human Rights and Consumer Involvement**

   (a) **Human Rights Committee**: CCBC has a Human Right Committee with several agency clients serving on the Committee. The Organization's Human Rights Officer attends committee meetings and serves as liaison between the Committee and the Management Team, and the governing Board. The Human Rights Committee follows DMH guidelines 104 CMR 15.03(13) (a-f) and 15.03(5) (I) for Community Programs.

   The responsibilities of the Committee include, but are not limited to:

   - Review of Human Rights complaints.
   - Review proposed Agency policies, which may have an impact on human rights.
   - Review and monitor any research projects of the Agency which involve consumers.
   - Annual visits and inspections of Agency sites, with recommendations reported to the Management Team.

   (b) **Consumer Involvement includes a variety of activities to facilitate consumer participation in the development and review of their service plan and in the review and evaluation of the Agency's programs and services.**

   These processes include:

   - A commitment to person-centered care and treatment where the consumers' needs and preferences are incorporated into all aspects of the service plan.
   - Inclusion of those with lived experience in all of the organization's major programs. Those with lived experience play a critical role in ensuring that programs and services are person-centered and sensitive to the needs, preferences and goals of those receiving care. Those with lived experience bring a particular sensitivity to the attitudes, processes and approaches that facilitate a recovery oriented treatment system. Those with lived experience can also serve as role models for those in early stages of recovery and can serve to illustrate that recovery is possible and achievable;
   - Program specific satisfaction surveys that gather data with respect to consumer perception of service delivery.

2.3.2.1 Specific plan on how our organization shall collaborate with hospital to achieve goals related to ED diversion and ensure timely response

ESP RFR Attachment 2.3.2 – Taunton/Attleboro Catchment Area

2.3.2 ED-specific plans related to ED diversion and timely response

2.3.2.1 Hospital Diversion Plans

2.3.2.1.1 Please describe how you shall work with Morton Hospital Emergency Department in an ongoing, collaborative, and integrated fashion.

CCBC will establish a working relationship with the **Morton Hospital ED** at a number of levels:

CCBC Contact	Hospital ED Contact	Scope of Collaboration
CEO	CEO	Negotiate Memorandum of Understanding
ESP Medical Director	ED Medical Director	Establish working protocols on medical and psychiatric issues and develop criteria on level of care for inpatient, CCS and community alternatives. Act as final arbiters of clinical presentations and dispositions; approval of clinical policies on ESP activity. Participate in monthly community stakeholder meetings
Psychiatrist On- Call	ED Physician	CCBC psychiatrist provides consultation on acute cases, including recommendations for psychopharmacology to stabilize acute patients who have experienced extended stays in the ED
ESP Program Director	ED Nurse Manager	Review monthly statistics; identify cases for monthly review; resolve logistical issues on timeliness and ESP staffing; ensure ongoing communication during ED back- ups; Implement MOU

CCBC will assign one ESP clinician to the Morton Hospital Emergency Department. They will be available to provide mobile crisis interventions at the hospital ED from 4 p.m. to midnight Monday through Friday. Additional staff can be deployed from the Norton community based location on weekends.

The CCBC clinician will work closely with the triage nurse and the ED physician in charge to provide timely assessments and joint treatment planning. The ESP clinician will have access to a telephone.

The ESP program director will schedule regular meetings every other month to discuss the working arrangement. The goal is to improve communication, validate response times, assure CCBC accountability to ED staff, and resolve any hospital issues with the appropriate ED managers. The ESP program director and the ESP medical director will attend the meeting. **With a regional approach CCBC ESP will combine these meetings with the regular meetings with Sturdy Memorial Hospital. This arrangement will result in more efficient dissemination of information on methods of reducing utilization of both ED's.**

2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served by that hospital, and the community serviced by that hospital--for how

you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP's alternative community-based settings and services.

The population served by Morton Hospital ED represents the diverse cultures of the city of Taunton with a higher concentration of Medicaid and uninsured than the demographics, including a higher concentration of Portuguese-speaking client, including children. The CCBC ESP will be able to meet the needs of these clients based on its successful staffing and support for other CCBC programs in the Taunton-Attleboro catchment area. In addition to recruiting bilingual/bicultural front office staff, CCBC will actively recruit clinicians who speak Portuguese, Spanish and other languages.

CCBC will deploy three strategies to divert behavioral health clients from the ED:

- First, CCBC will work in the community with referral sources about the increased mobile capacity of the ESP and the availability of peer specialists and family partners.

- Second, CCBC and the ED staff will conduct a survey of ED clients who present for behavioral health assessment. The survey will ask whether the client or referral sources called CCBC before, whether they considered a mobile visit or a visit to the ESP community site before coming to the ER, and whether their health care provider had counseled them about alternatives to the ED. CCBC will use the results of this survey to identify the best target for follow up information and social marketing in the community.

- Third, CCBC will work with ED staff to triage follow up in the community-based ESP and at the CCBC clinic site in Taunton to try to minimize the pattern of clients returning to the ED by habit even in non-crisis situations.

CCBC will set up meetings with the ED administrators at Morton Hospital to identify cohorts, or sub-populations familiar to them who may be considered "convenience" users of ED services. The ESP will follow up with these providers who are identified from these cohorts to develop alternative response plans, informing them that the CCBC Triage and Mobile Crisis Intervention are viable alternatives to the ED as first point of contact.

CCBC will also have a standing offer from the ESP Medical Director to the ED program director to convene an ad hoc meeting when a complex presentation cannot be immediately resolved. The ESP will take the responsibility to convene interested parties, including the Managed Care Entity, state agencies who are involved with the member, primary care providers, and other behavioral health providers.

2.3.2.1.3 Describe how you will minimize the need for ED "boarding" and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.

CCBC recognizes that ED boarding is a serious problem across the Commonwealth. Both Sturdy Memorial and Morton Hospitals have had unusual spikes in volume that can precipitate

ED Boarding for days. There are several ways to minimize the spikes and to quickly address the high volume cases:

- CCBC will establish an electronic method of developing and storing Safety Plans, Crisis Plans and other upstream plans that can provide structured interventions before clients at high risk are referred to the ED.

- CCBC's ESP psychiatrist will also be available 24/7 to consult with the treating ED physician on appropriate medication regimen for members with extended stays in the ED and for members who are highly agitated and at acute risk of harm to self or others. Some of these interventions are likely to stabilize clients and enable referrals to CCS as a diversion from inpatient hospitalization, thus reducing the volume in the ED's.

- The ESP staff can track bed availability using the MABHS "Bedfinder" to alert staff, ED managers, and community stakeholders of limited availability and prioritize timely hospitalizations.

- ESP and ED staff will develop criteria to flag complex cases such as adults with histories of violence, children and adolescents with SED and Autism or PDD, and adolescents with recent histories of violence. When the clinician completes an assessment with this type of presentation, the ESP program director will inform the MCE immediately to request assistance with placement and plan to convene the appropriate community stakeholders to plans for disposition.

2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. What volume do you anticipate initially, and what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis? Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED?

CCBC will monitor compliance within the time frames based on a daily review of the ESP case records from the previous day by the program director and a monthly review of aggregated data by the Program Director and the hospital ED staff. This information will be discussed at the regular meetings. Real time accountability will be assured by the availability by pager of all CCBC-ESP supervisory and managerial personnel, up to and including the Program Director.

CCBC estimates that there will be about 70 requests for crisis intervention each month in the Morton ED. When the demand for ESP evaluations creates delays in timely access in the ED, CCBC will provide additional back-up from the "all-around" clinician available through the Norton community-based location who can be dispatched by the Triage staff. CCBC expects to reduce that amount to 60 per month in the FY 2017.

A contract with Morton Hospital will be signed before January 1, 2016.

ESP RFR Attachment 2.3.2 – Taunton/Attleboro Catchment Area

2.3.2 ED-specific plans related to ED diversion and timely response

2.3.2.1 Hospital Diversion Plans

2.3.2.1.1 Please describe how you shall work with Sturdy Memorial Hospital Emergency Department in an ongoing, collaborative, and integrated fashion.

CCBC will establish a working relationship with the **Sturdy Memorial Hospital ED** at a number of levels:

CCBC Contact	Hospital ED Contact	Scope of Collaboration
CEO	CEO	Negotiate Memorandum of Understanding
ESP Medical Director	ED Medical Director	Establish working protocols on medical and psychiatric issues and develop criteria on level of care for inpatient, CCS and community alternatives. Act as final arbiters of clinical presentations and dispositions; approval of clinical policies on ESP activity. Participate in monthly community stakeholder meetings.
Psychiatrist On- Call	ED Physician	CCBC psychiatrist provides consultation on acute cases, including recommendations for psychopharmacology to stabilize acute patients who have experienced extended stays in the ED.
ESP Program Director	ED Nurse Manager	Review monthly statistics; identify cases for monthly review; resolve logistical issues on timeliness and ESP staffing; ensure ongoing communication during ED back- ups; Implement MOU.

CCBC will assign one ESP clinician to the Sturdy Memorial Hospital Emergency Department. They will be available to be on site from 4 p.m. to midnight five days per week. The CCBC clinician will work closely with the triage nurse and the ED physician in charge to provide timely assessments and joint treatment planning. The ESP clinician will have access to a telephone in the ED.

The ESP program director and the ESP medical director will schedule monthly meetings at the outset to discuss the working arrangement. The goal is to improve communication, validate response times, assure CCBC accountability to ED staff, and resolve any hospital issues with the appropriate ED managers.

2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served by that hospital - for how you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP's alternative community-based settings and services.

The clients served by the Sturdy Memorial ED represent the demographics of the surrounding communities in the Taunton-Attleboro catchment area. In addition, clients from local DMH group homes and nursing homes also present at the Sturdy Memorial ED. CCBC's

ESP clinicians have the skills and experience to conduct thorough crisis interventions with clients from these populations.

CCBC will deploy three strategies to divert behavioral health clients from the ED:

- First, CCBC will work in the community with referral sources about the increased mobile capacity of the ESP and the availability of peer specialists and family partners.

- Second, CCBC and the Sturdy Memorial ED staff will conduct a survey of ED clients who present for behavioral health assessment. The survey will ask whether the client or referral sources called CCBC before, whether they considered a mobile visit or a visit to the ESP community site before coming to the ER, and whether their health care provider had counseled them about alternatives to the ED. CCBC will use the results of this survey to identify the best target for follow up information and social marketing in the community.

- Third, CCBC will work with ED staff to triage follow-up in the Community-Based Location nearby the hospital ED for urgent psychopharmacology and at nearby clinic sites in the area to minimize the pattern of clients returning to the ED by habit even in non-crisis situations.

CCBC will have meetings at Sturdy Memorial Hospital where the ED administrators identify cohorts, or sub-populations familiar to them who may be considered "convenience" users of ED services. The ESP will follow-up with providers identified in the Sturdy Memorial survey to develop alternative response plans, informing them that the CCBC Triage and Mobile Crisis Intervention are viable alternatives to the ED as first point of contact.

CCBC will also have a standing offer from the ESP medical director to the ED program director to convene an ad hoc meeting when a complex presentation cannot be immediately resolved. The ESP will take the responsibility to convene interested parties, including the Managed Care Entity, state agencies who are involved with the member, primary care providers, and other behavioral health providers.

2.3.2.1.3 Describe how you will minimize the need for ED "boarding" and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.

CCBC recognizes that ED boarding is a serious problem across the Commonwealth. Both Sturdy Memorial and Morton Hospitals have had unusual spikes in volume that can precipitate ED Boarding for days. There are several ways to minimize the spikes and to quickly address the high volume cases:

- CCBC will establish an electronic method of developing and storing Safety Plans, Crisis Plans and other upstream plans that can provide structured interventions before clients at high risk are referred to the ED.

- CCBC's ESP psychiatrist will also be available 24/7 to consult with the treating ED physician on appropriate medication regimen for members with extended stays in the ED and for members who are highly agitated and at acute risk of harm to self or others. Some of these interventions are likely to stabilize clients and enable referrals to CCS as a diversion from inpatient hospitalization, thus reducing the volume in the ED's.

- The ESP staff can track bed availability using the MABHS "Bedfinder" to alert staff, ED managers, and community stakeholders of limited availability and prioritize timely hospitalizations.

- ESP and ED staff will develop criteria to flag complex cases such as adults with histories of violence, children and adolescents with SED and Autism or PDD, and adolescents with recent histories of violence. When the clinician completes an assessment with this type of presentation, the ESP program director will inform the MCE immediately to request assistance with placement and plan to convene the appropriate community stakeholders to plans for disposition.

2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. What volume do you anticipate initially, and what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis? Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED?

In addition to the ESP clinician assigned to Sturdy Memorial Hospital ED on weekday evenings, CCBC will provide back-up and triage from the centralized CCBC ESP Team at the Community-Based Location in Norton. Real time accountability will be assured by the availability by pager of all CCBC ESP supervisory and managerial personnel, up to and including the program director. CCBC ESP expects to complete on average about 71 crisis interventions monthly in the Sturdy Memorial ED, but will reduce it to 60 per month in FY 2017 with creative strategies to increase mobile crisis interventions outside of the ED.

CCBC monitors compliance within the timeframes based on a daily review of the responsiveness from the ESP case records from the previous day and a monthly review of aggregated data by the program director and the hospital ED staff. This information is discussed at meetings that are held every month. **The CCBC regional approach will allow for a full-time ESP quality/risk manager to develop, distribute, collect and analyze the response time data, the survey data and the results of the corrective actions to achieve MBHP goals and in both the Brockton and Taunton-Attleboro catchment areas.**

The contract with Sturdy Memorial Hospital will be operational by January 1, 2016.

2.4.3.1 Professional development activities and trainings that our organization has provided staff related to resilience, rehabilitation, and recovery within the last two years

ESP RFR Attachment 2.4.3.1

List of Trainings and Professional Development Activities Related to Resiliency, Rehabilitation and Recovery in the Past Two Years

- 2013 Mass Psychiatric Rehabilitation Association (PRA) Conference: Connections for Life: Recovery and Community Partnerships
- 2014 Mass PRA Conference-Supporting the Recovery Workforce Toward Lifelong Learning
- Training taken on-line by CCBC staff from CCBC's On-Line Training Resource - *Relias*:
  - WRAP (Wellness Recovery and Action Plan) Values and Ethics:
  - Mental Health Recovery and WRAP (Wellness Recovery Action Plan);
  - Intentional Peer Support-A Different Kind of Relationship;
  - Mental Health Recovery and WRAP (Wellness Recovery Action Plan):
  - Key Recovery Concepts;
  - Peer Support: Supporting One Another in Recovery;
  - A Culture-Centered Approach to Recovery.
- "Illness Management and Recovery" - a three day training by the Bridge of Central Massachusetts
  - CCBC staff also participated in an online webinar, "Peers as Crisis Service Providers II" sponsored by SAMHSA

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2.5.2.1.5 Professional development activities and trainings that our organization has provided for staff relative to cultural competence with the last two years

ESP RFR Attachment 2.5.2.1.5

List of Trainings and Professional Development Activities Related to Cultural Competence in the Past Two Years

CCBC utilizes the Relias Training System to provide and track all staff training since September 2014. Training provided in cultural competence is included in the core competency curriculum for many CCBC programs, including Community Based Flexible Support, DBT, and PACT Services.

Training over the past two years included:

- A Culture Centered Approach to Recovery
- Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence
- Cultural Issues in Mental health Treatment
- Cultural Issues in Treatment for Paraprofessionals
- Cultural Diversity

In Person Trainings attended:

- BSAS training on implementing the CLAS Principles
- Military Culture, In-person BSAS training by Ben Cluff
- Mass-PRA Conference-2013: Allies in Recovery: Learning to Engage Racially and Culturally Diverse Adults with Psychiatric Conditions
- Mass-PRA Conference 2014: Courageous Conversations: Unpacking the Construct of Race
- DPH Ounce of Prevention conferences: 2015: Adewale Troutman, MD, who spoke on "Creating a Health Equity Movement."
- NACCHO conference 2015-" Cultivating a Culture of Health Equity"

3.1.9.1.1 – 3.1.9.1.3

Job description of ESP Program Director and Resumes of Quality Management Coordinator and Medical Director

ESP RFR Attachment 3.1.9.1.1

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **102 Program Director**

Position Title: Program Director

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: Vice President of Emergency and Diversionary Services

Summary of Position:

The Program Director (PD) is responsible for the overall operations of the ESP, including the supervision of all ESP staff and the clinical effectiveness of the program. The PD's primary function is to:

- Share responsibility with the ESP Medical Director for the clinical oversight and quality of care across ESP services.
- Responsible for the administrative and financial oversight of the ESP contract.
- Serve as primary point of accountability to MBHP and MCEs for the ESP.
- Ensure compliance with all requirements and performance specifications, including standard assessment tools, electronic encounter forms, and other data collection mechanisms.

Education/Training:

- Master's degree in Social Work or related mental health field or doctoral level.
- Must be independently licensed (LICSW, LMHC, PhD).
- Must have at least five (5) years post-graduate experience providing behavioral health services to children, families, and adults.
- Must have at least three (3) years of supervisory and/or management experience.

Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, potential safety issues, etc.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.

- Must be able to articulate and promote a recovery-orientation that is resolution-focused, strengths-based, and culturally competent.
- Ability to manage resources, including the hiring and retention of culturally competent staff.
- Possess knowledge and practice skills regarding Continuous Quality Improvement (CQI).
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties, as well as the written skills required to manage an electronic health record system.

Responsibilities:

- Administer the recruiting and hiring process for all ESP employees.
- Develop and maintain community connections with key stakeholders
- Develop and maintain programmatic policies and procedures to support a high fidelity ESP.
- Develop and maintain the training process and protocols for all new staff.
- Provide weekly individual and group supervision to staff and conduct regular performance reviews.
- Supervise program staff, which includes providing clinical support and oversight.
- Provide monthly trainings to all program staff to ensure compliance with all agency and managed care entities mandates.
- Oversee and ensure that all managed care entities' performance specifications and medical necessity criteria are being maintained by program.
- Collaborate with community resources, local and state agencies, schools, therapists and vocational programs.
- Facilitate monthly meetings and maintain collaborative partnerships with managed care entities and various states agencies including DMH, MCI and DCF.
- Provide oversight and support to all staff in ensuring they are completing all mandated responsibilities. This includes various quality management tasks and managing any staff disciplinary issues/performance improvement efforts.
- Manages various reports needed within the program to meet Mass Health requirements
- Provides on-going support to all team members as needed.
- Provides clinical oversight to all program matters and cases.
- Assist in the development of fiscal budgets and maintain program operations within allotted budget.

List Other Job Requirements:

All staff must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.

All staff must maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren). All staff must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

ESP RFR Attachment 3.1.9.1.1

Physical Requirements:

All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance. All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

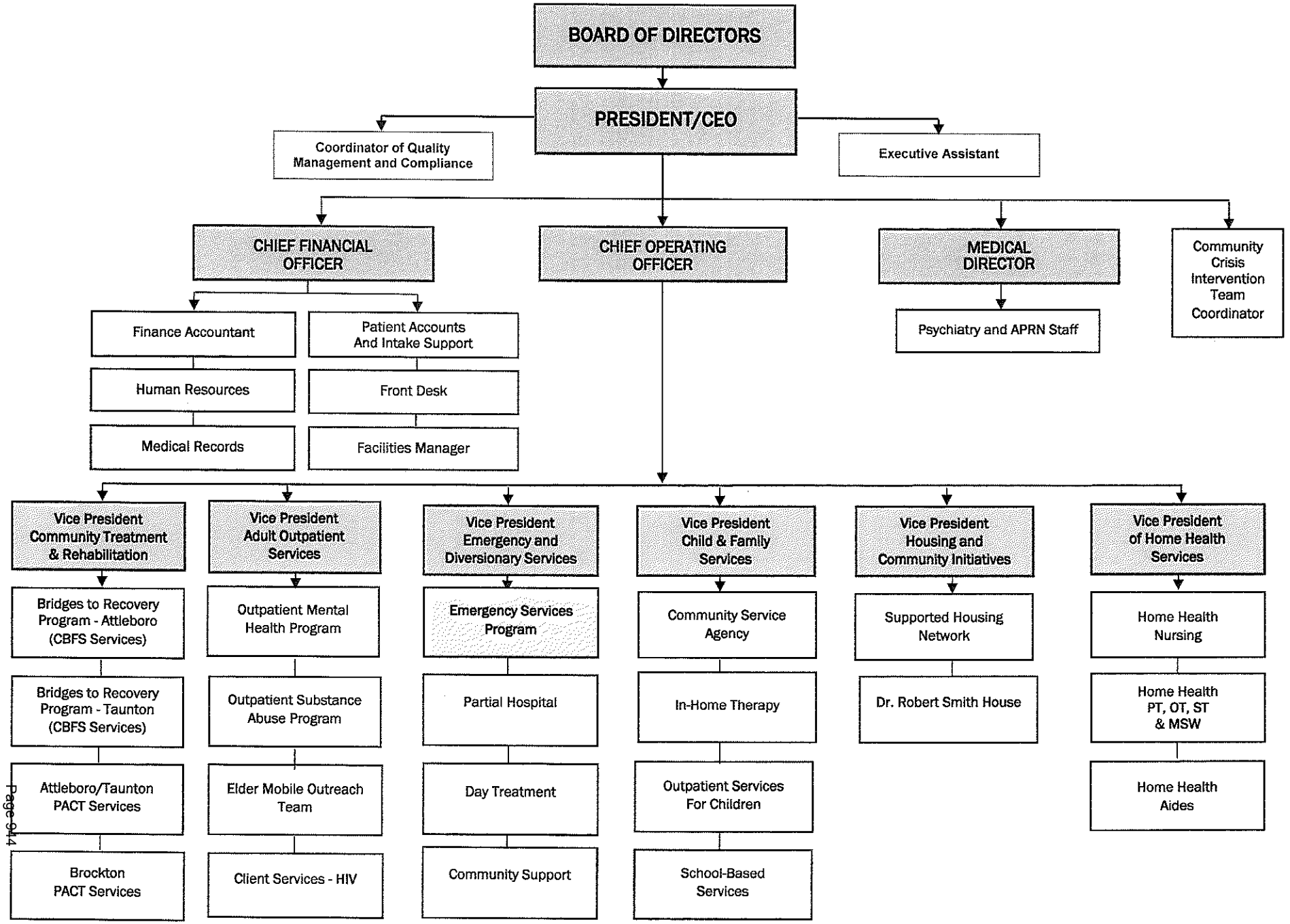
_____ _____

Signature Date

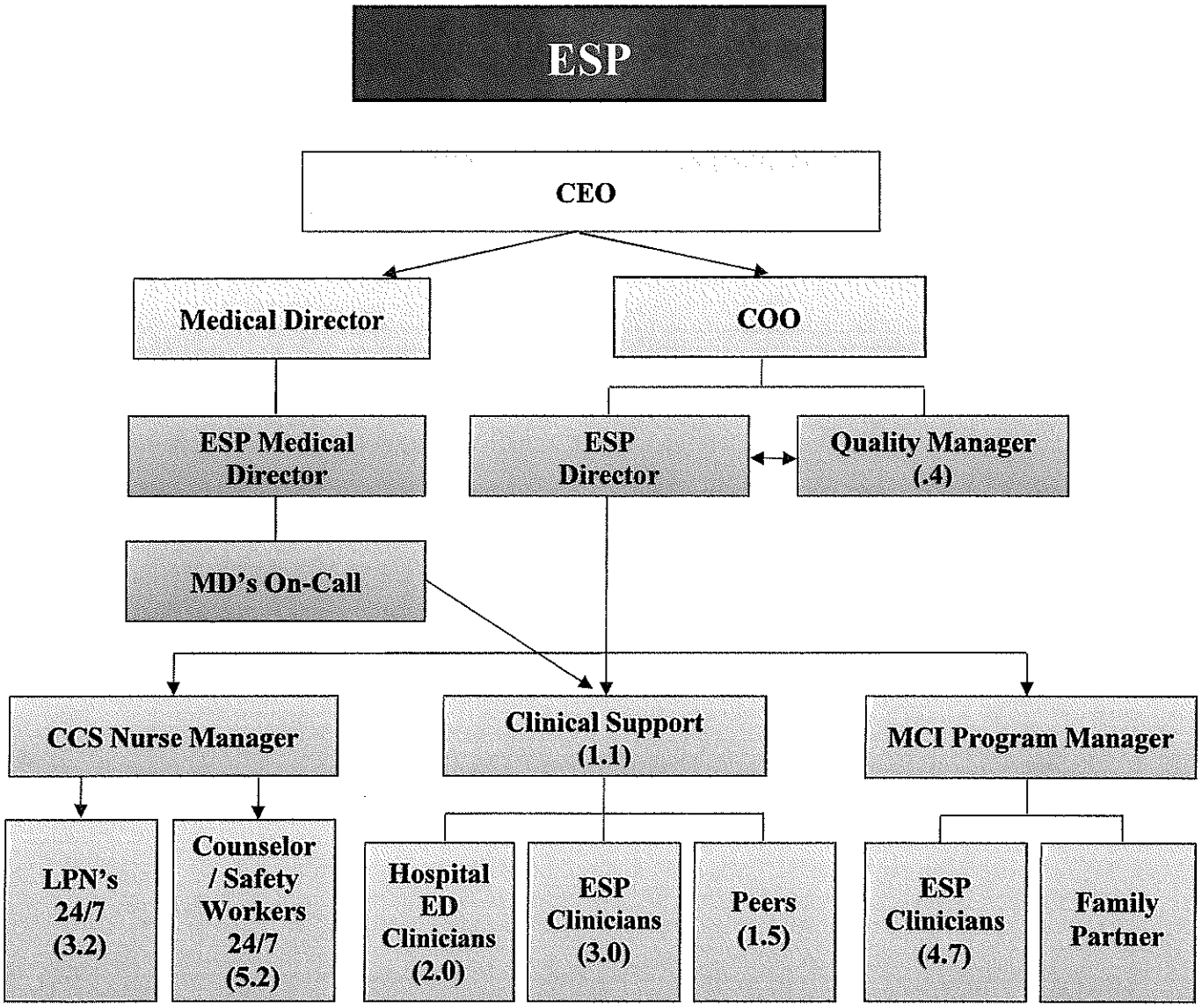
3.1.9.2 Organization chart that indicates where ESP key staff shall sit within the organization at an administrative and supervisory level

Community Counseling of Bristol County, Inc.

TABLE OF ORGANIZATION



ESP RFR Narrative Response – Attachment 3.1.9.2



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CCBC Central Triage and Liaison Role with ESP Sites

Brockton Site
Unique Toll Free Number:

- Direct line from ED's, DCF, DMH, DYS, CBFS, and PACT.
- Open line 8 am – 8 pm.

Taunton-Attleboro Site
Unique Toll Free Number:

- Direct line from ED's, DMH, DYS, CBFS, PACT, and Police.
- Open line 8 am – 8 pm.

- CCBC Central Triage 8 pm – 8 am.
- Roster of on-call clinicians and assigned clinicians to each site.
- Central triage rotates between Brockton and Taunton/Attleboro Sites.
- After 8 pm toll free lines merge.
- Central triage keeps rolling roster of clinicians on site, clinicians doing evaluations, clinicians on-call, doctors on-call, and relief staff on-call (Peers, FP's, Safety staff, CCS staff).
- CCS census at each site.

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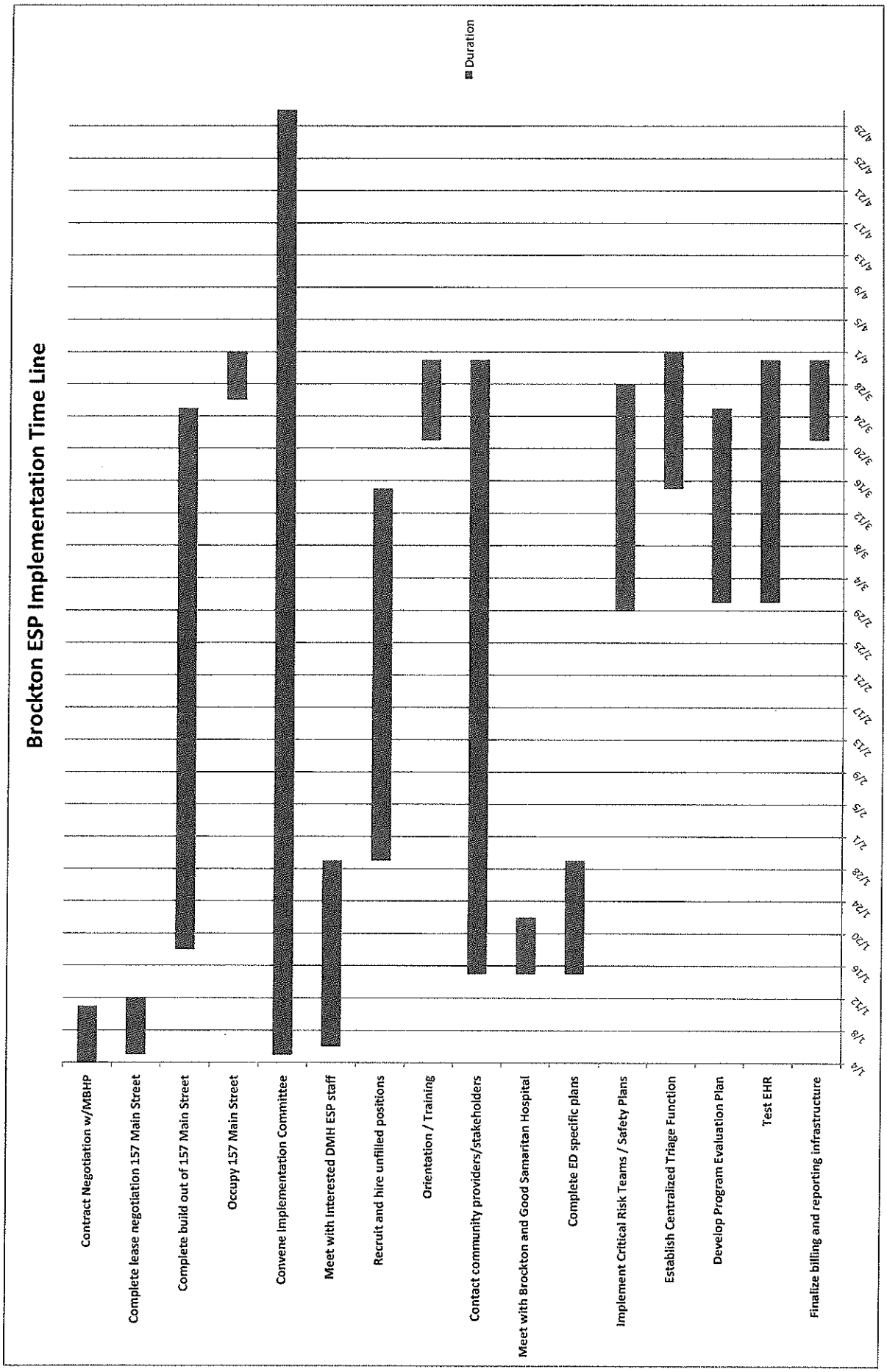
3.4.3.3 Implementation plan outlining how and when co-location shall be achieved within three months of the initiation of contract

ESP RFR Attachment 3.4.3.3 - Brockton Catchment Area



3.5.3.3 – 3.5.3.6

Evidence of competence working in partnership with youth, parents, and caregivers of youth with mental health needs

Policies, procedures, and protocols developed for provision of behavioral health services to youth and families

Outcome data, quality improvement processes and satisfaction survey results focused on youth and families

Training, licensing certification and verification of expertise in providing behavioral health services to youth and families

Family Support Partner—Tier One Certification Checklist

Exercise		Date Verified
1	Pre Reading and Preparation for Training Exercise	
2	Tier One and Tier Two Certification	
3	The Principles of Wraparound	
4	The Phases and Activities	
5	The Theory of Change	
6	Staff Roles	
7	The VVDB Action Steps	
8	Challenges to Engaging Families	
9	Trust Building, Voice and Choice, and Self Efficacy	
10	Develop your own Family Scenario	
11	Behavioral Rehearsal of Engagement	
12	Initial Meeting with the Family (continues)	
13	Crisis Stabilization	
14	Your Personal Natural Supports	
15	Natural Supports in your Scenario Family	
16	Impact and Explaining the SNCD	
17	Life Domains	
18	Learning more about Wraparound & Spirituality Boundaries	
19	Long Range Vision and Prioritized Needs	
20	Family Culture	
21	Practicing the SNCD	
22	Explaining Wraparound to Custodial Agency Staff	
23	Preparing the Family and Team	
24	Recruiting a Reluctant Team Member	
25	Supporting Families towards Independence	
26	Completing the first SNCD	
27	Debriefing the SNCD Assignment	
28	Ensuring that SNCD drift does not occur	
29	Choose the Right Sequence for Planning	
30	Using the DVD family (Mariam) building "AJs plan, add strengths and set ground rules	
31	Adding to the Team Mission	
32	Prioritized Needs	
33	Developing Goals, Objectives and Measurement Strategies	

Exercise		Date Verified
34	Options and Action Steps	
35	The Terms of Functional Assessment	
36	Functional assessment	
37	Crisis plan	
38	Progress Tracking Measures	
39	Needs and Services	
40	Individualization of Transition	
41	Story Board Brainstorming	
42	Team Cohesion: Dealing with Team Fragmentation	
43	Recruitment of Surrogate Supports	
44	Family Culture in Area of Celebration of Milestones	
45	Building Self Efficacy for a Family	

Shadowing Activities		Date Verified
1	a. Observe engaging a family.	
	b. An additional observation of engaging a family.	
2	a. Observe preparing a family for the SNCD.	
	b. An additional observation of preparing a family for the SNCD.	
3	a. Observe a sample of gathering information.	
	b. An additional observation of gathering information.	
4	a. Observe identifying and building natural supports	
	b. An additional observation of identifying and building natural supports	
5	a. Observe preparing a family for a meeting.	
	b. An additional observation of preparing a family for a meeting.	
6	a. Observe recruiting team members.	
	b. An additional observation of recruiting team members.	
7	a. Observe planning meetings.	
	b. An additional observation of planning meetings.	

Supplemental Exercises		Date Verified
1	Layout the roles of Wraparound Staff in agency	
2	Behavioral rehearsal: Engaging families	
3	Behavioral rehearsal: Sharing your experience to prepare for SNCD	
4	Behavioral rehearsal: Gathering information	
5	Behavioral rehearsal: Identifying and building natural supports	
6	Behavioral rehearsal: Preparing a family for the initial WA meeting	
7	Behavioral rehearsal: Recruiting team members	

Coaching Debriefing Comments:

Wraparound Facilitator—Tier One Certification Checklist

Exercise		Date Verified
1	Pre Reading and Preparation for Training Exercise	
2	Tier One and Tier Two Certification	
3	The Principles of Wraparound	
4	The Phases and Activities	
5	The Theory of Change	
6	Staff Roles	
7	The VVDB Action Steps	
8	Challenges to Engaging Families	
9	Trust Building, Voice and Choice, and Self Efficacy	
10	Develop your own Family Scenario	
11	Behavioral Rehearsal of Engagement	
12	Initial Meeting with the Family (continues)	
13	Crisis Stabilization	
14	Your Personal Natural Supports	
15	Natural Supports in your Scenario Family	
16	Impact and Explaining the SNCD	
17	Life Domains	
18	Learning more about Wraparound & Spirituality Boundaries	
19	Long Range Vision and Prioritized Needs	
20	Family Culture	
21	Practicing the SNCD	
22	Explaining Wraparound to Custodial Agency Staff	
23	Preparing the Family and Team	
24	Recruiting a Reluctant Team Member	
25	Supporting Families towards Independence	
26	Completing the first SNCD	
27	Debriefing the SNCD Assignment	
28	Ensuring that SNCD drift does not occur	
29	Choose the Right Sequence for Planning	
30	Using the DVD family (Mariam) building "AJs plan, add strengths and set ground rules	
31	Adding to the Team Mission	
32	Prioritized Needs	

Exercise (Continued)		Date Verified
33	Developing goals, objectives and measurement strategies	
34	Options and action steps	
35	The terms of functional assessment	
36	Functional assessment	
37	Crisis plan	
38	Progress tracking measures	
39	Needs and services	
40	Individualization of transition	
41	Story board brainstorming	
42	Team cohesion: Dealing with team fragmentation	
43	Recruitment of surrogate supports	
44	Family culture in area of celebration of milestones	
45	Building self efficacy for a family	
Shadowing Activities		**Date Verified**
1	a. Engaging families in a meeting	
	b. An additional experience engaging families in a meeting	
2	a. Strengths, Needs, and Culture Discovery with a family	
	b. An additional experience with SNCD	
3	a. Preparing a family for a meeting	
	b. An additional experience preparing a family for a meeting	
4	a. Recruiting team members	
	b. An additional experience recruiting team members	
5	a. First team meeting	
	b. An additional experience of the first team meeting	
6	a. Functional assessments	
	b. An additional experience with functional assessments	
7	a. Crisis team meetings	
	b. An additional experience with crisis team meetings	
Supplemental Exercises		**Date Verified**
1	Layout the roles of Wraparound Staff in agency	
2	Behavioral rehearsal: Engaging families	
3	Behavioral rehearsal: The SNCD	
4	Behavioral rehearsal: Preparing the family for a team meeting	
5	Behavioral rehearsal: The first team meeting	
6	Behavioral rehearsal: Doing a functional assessment	
7	Behavioral rehearsal: Crisis planning meeting	

ESP RFR Attachment 3.5.3.5
FY 2014 Annual Member Satisfaction Survey Data Results

Q#	QUESTION	STRONGLY AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NOT ANSWERED	TOTAL RESPONSES
1	Does your care coordinator help you to understand the Community Service Agency and Wraparound?	31	1	0	1	1	0	34
		91%	3%	0%	3%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
2	Is involvement in community-based activities reflected in the care planning process?	23	5	3	0	1	2	34
		68%	15%	9%	0%	3%	6%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	91%						
3	Are there on-going and persistent efforts to engage natural supports?	27	4	1	2	0	0	34
		79%	12%	3%	6%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
4	Will natural supports continue to be involved with your family when CSA Wraparound is finished?	26	1	5	2	0	0	34
		76%	3%	15%	6%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
5	Does your care coordinator help you to identify and help you to work on the needs that are most important to your family?	28	5	0	0	1	0	34
		82%	15%	0%	0%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
6	Has your care coordinator improved your confidence and ability to get your family's needs met?	29	1	3	0	1	0	34
		85%	3%	9%	0%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
7	Does your care coordinator use your family's voice and choice in the problem solving process?	29	2	2	0	1	0	34
		85%	6%	6%	0%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
8	Does your care coordinator provide opportunities to celebrate and mark your accomplishments?	26	4	2	0	0	2	34
		76%	12%	6%	0%	0%	6%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						

ESP RFR Attachment 3.5.3.5
FY 2014 Annual Member Satisfaction Survey Data Results

Q#	QUESTION	STRONGLY AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NOT ANSWERED	TOTAL RESPONSES
9	Does your care coordinator provide you with information about community, advocacy resources, and ways to connect with others?	28	0	3	2	1	0	34
		82%	0%	9%	6%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	91%						
10	Does your care coordinator pay attention and demonstrate sensitivity to your preferences and culture?	29	2	2	1	0	0	34
		85%	6%	6%	3%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
11	Are natural supports engaged in the planning and the implementation process of Wraparound efforts?	21	4	7	1	1	0	34
		62%	12%	21%	3%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
12	Are community-based ideas brainstormed, prioritized, and utilized in care planning meetings?	26	2	4	0	1	1	34
		76%	6%	12%	0%	3%	3%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
13	Is your family confident that in the occurrence of a crisis, the team can keep your child in the community?	27	3	3	1	0	0	34
		79%	9%	9%	3%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
14	Does your care coordinator help create a team of people to work on your family-driven plan based upon your vision?	29	1	1	3	0	0	34
		85%	3%	3%	9%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	91%						
		379	35	36	13	8	5	

Families that received surveys	220
Families declined to participate.	201
Family submitted a blank survey.	0
Families who submitted written comments.	24
Families who submitted surveys without written comments.	10

Family Support Partner (FSP)
Skill Sets, Functions, and Roles

Functions of the Family Support Partner

1. Partner with the Wraparound Staff (Wraparound Facilitator, Youth Support Partner and Wraparound Coach) to ensure that the wraparound process is provided with high fidelity and is successful for families.
2. Provide direct support to parents and child and family team members to carry out action steps from the wraparound plan.
3. Connect families to other families to strengthen natural supports and provide system level family voice and choice.

Family Support Partner Roles

- The FSP role models effective personal interactions and behavior.
- The FSP advocates for and supports families to identify their own strengths, needs, culture and vision and get these needs met.
- The FSP shares their own experiences to build relationships with and help families be successful with wraparound.
- The FSP mentors families to improve their confidence and ability to advocate for and effectively manage the services and supports for their own family.
- The FSP supports development, reconnection and strengthening of natural supports for families.
- The FSP partners with the wraparound staff (e.g., wraparound facilitator, youth support partner, and wraparound coach) to provide a high fidelity wraparound process.
- The FSP supports development of Family to Family Supports. .

Family Support Partner Skill Sets for Roles

<u>Models Effective Interactions</u>

1. The FSP encourages and models commitment to the family and encourages the family to believe in their future and to stick with the process.
2. The FSP honors the culture of the family by keeping their own views in check.
3. The FSP aligns themselves with the family to support the family's choices.
4. The FSP engages in strategic and mutually respectful partnerships with the facilitator, youth support partner and other team members.
5. The FSP role models strengths-based interactions by not blaming or shaming others in the presence of the family or other team members.
6. The FSP models protection of confidentiality by never talking about wraparound families outside of the appropriate work setting, without the families' permission and input.
7. The FSP checks in with the family during and at the end of interactions and activities to determine family satisfaction with the process.

Advocates for and Supports Families Needs

8. The FSP help the family understand that support can take on many different forms and that the family will determine what the support will look like for them.
9. The FSP actively listens to the family and takes notes about support needs, clarifying points with the family and facilitator.
10. The FSP shares experiences with families to help them understand how wraparound can help families meet positively framed needs.
11. The FSP educates and supports family members to use their own voice to express their needs and preferences (e.g., "do for, do with, and cheer on").
12. The FSP supports self advocacy by providing the least amount of support that will be successful with planned fading of support (do for, do with and then cheer on).
13. The FSP recognizes and values the differences among families, discovering the unique culture of each family and using this information to determine how they can best advocate for their family.
14. The FSP helps family members understand and to explain their culture and strengths to get their plan to match their family culture.
15. The FSP understands family needs, culture, strengths and preferences and supports families to advocate for them.
16. The FSP helps the family understand the mandates and perspective of other team members, while keeping family perspective at the forefront of team discussions.

Sharing Your Experience

17. The FSP shares their own experiences to develop a shared sense of understanding and relationship with families.
18. The FSP may share their own experience with wraparound to give the family an understanding of how the process can be an opportunity for them.
19. The FSP may share their own experience with the different activities of the wraparound process to give the family an understanding of how the process can affect them.
20. The FSP may prepare the family for the strengths, needs, and culture discovery conversations through sharing personal and other family experiences.
21. The FSP may give personal examples to help clarify questions.
22. The FSP share their own experience of how being honest and open helped them to get better support.

Mentors Families to Improve Self Efficacy (Confidence they can be successful)

23. The FSP observes and interacts with the family to help the family understand and celebrate strengths.
24. FSP knows available resources within a community and helps the families in choosing and accessing those that address their needs.
25. The FSP educates and supports the family in the importance of maintaining and using documentation to advocate and control the process of service and support.
26. The FSP helps families to understand how to store and use documentation to support services for their children.
27. The FSP helps and encourages families to find and develop effective self advocacy skills.

Supports Development, Reconnection and Strengthening of Natural Supports for Families

28. The FSP may share personal experiences and reasons why natural supports can be important for families.
29. The FSP helps families identify reciprocal relationships (what each person gets from the relationship) that define and sustain natural supports.
30. When families do not easily identify natural supports an FSP may be enlisted to do more in depth work with the family to identify potential supports.
31. The FSP may work with the family to plan for contacting potential natural support team members and orienting them to the process.
32. The FSP may meet with natural supports to get them ready for initial or follow-up wraparound meetings.
33. The FSP helps families to plan and reconnect with extended family and natural supports based on family voice and choice.
34. The FSP helps families and natural supports work through barriers to partnership.

Supports Implementation of the Phases and Activities of Wraparound. (The FSP partners with the wraparound facilitator and youth support partner to complete the activities of the wraparound process).

Wraparound Phase One: Engagement

35. The FSP may assist the wraparound facilitator by doing one on one orientation, sharing their own experience with wraparound, and helping the family to understand how wraparound might be a positive opportunity for them.
36. The FSP helps the family understand what is different about wraparound by explaining wraparound from a family's perspective.
37. The FSP may provide written materials and other resources to help families understand wraparound, review these materials with the family and answer questions.
38. The FSP explains their role including what they may do and limits on the role.
39. The FSP may assist the wraparound facilitator in explaining confidentiality and client rights and responsibilities, and as needed, help ease these fears and answer questions from a family perspective.
40. The FSP may assist in the development of crisis stabilization plans to make sure the plans are individualized, based on voice and choice and are realistic for the family.
41. If a family member is very distrustful of systems and does not want to sign consent and release forms, the FSP may need to do some one on one time with the family member to help them understand why sharing could benefit their family.
42. The FSP may help the family prepare for the SNCD by helping the family identify their strengths, needs, culture and vision from a family perspective.
43. The FSP may help the family prepare for the SNCD by understanding why wraparound works better when focused on positive needs and reframing negative concerns into positive needs.
44. The FSP may help the family to gather and organize information that they will need to advocate for their child.

45. The FSP observes the SNCD conversations to ensure that the family does not answer questions in the way they think the wraparound facilitator wants them to answer, and is the truth teller or negotiator of this issue should it arise.
46. The FSP may take the completed summary document to the family and sit with them and go over it to make sure it is correct and to add to the document as needed.
47. The FSP may be able to help the family find natural supports within the community to help with the planning process.
48. The FSP may spend additional time with the family to prepare them for the initial wraparound meetings making sure they understand each of the parts of the agenda and are prepared to use their voice and choice.
49. If the family wants the FSP at planning meetings the FSP works with the family to decide the role the FSP will play in advance of the meeting.
50. The FSP works with the wraparound facilitator and youth support partner to make sure family needs are met in the scheduling, location and agenda for the wraparound planning meetings .
51. The FSP may contact team members who will need support to get to the meeting and to participate in the meeting.

Wraparound Phase Two: Planning

52. The FSP helps other team members to understand the importance of and feel comfortable with family voice and choice.
53. The FSP encourages thinking beyond the usual services and supports.
54. The FSP is determined to ensure family voice and choice during needs selection. Ideally, the FSP comes to the meeting with an understanding of family wishes in this area (and on goals and objectives).
55. The FSP agrees to take on action steps that are compatible with their role and that they have the time and resources to complete them.
56. The FSP is careful to ensure that the family understands the reason for the crisis plan and why it is being done.
57. The FSP explains the functional assessment process and shares how this process has helped other families and the importance of in-depth accurate information.
58. The FSP checks in with the family to ensure they feel they were heard and that the developed plan is individualized to who they are and is realistic.

Wraparound Phase Three: Implementation

59. The FSP reviews the written plan with the family to make sure they understand it, agree with it and have any resources or supports needed to implement it.
60. The FSP encourages the family in completing action steps, through motivation, support, reminders.
61. The FSP works with the family to determine if the plan is working and to decide when they need to ask for changes in the plan.
62. The FSP checks with the family on emerging needs and if the needs should be brought to the team and if new strategies are needed.
63. The FSP may help the family to update their various documents and information used to advocate for their child and family, helps the family to identify the strengths of their

natural support systems and communities and helps them identify ongoing needs to be more connected as needed.

64. The FSP constantly checks with the family on their feeling of support from the team, and if they are beginning to feel a lack of support, too much support, or if the family is not content with the team for any reason.
65. The FSP can be used to spend additional time with the family to prepare them for follow-up wraparound meetings.
66. The FSP works creatively with the family and their team to make sure that progress does not stop when barriers and challenges occur.
67. The FSP models positive collaboration with all team members to build team cohesion (togetherness).
68. The FSP documents their work with the family through progress notes that meet the criteria set by the participating agencies.

Wraparound Phase Four: Transition

69. The FSP supports the family to identify the needs that will continue to need attention after formal wraparound ends.
70. The FSP helps the family to identify the successes they have had and the lessons they have learned through the wraparound process.
71. The FSP checks in with the family to ensure that the modification to the wraparound process is understood and is culturally competent to the family.
72. The FSP checks with the family to see how and if they would like to celebrate success in a culturally competent manner.
73. Ideally the FSP should be committed to remaining with the family as long (and no longer) than the family needs / desires. The FSP supports the family through self-advocacy. Phasing out the FSP should be a gradual process as families expand their role.

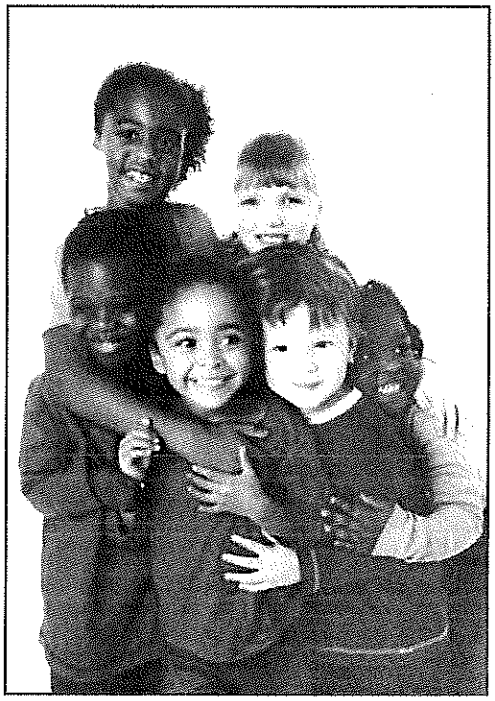
<u>Supports Development of Family to Family Supports</u>

74. The FSP may link the family up with other graduates of the process who can be team members and natural supports.
75. The FSP gives families opportunities to become part of the larger circle of families where they can find support from other parents and caregivers with similar experiences.
76. FSPs connect families to local family groups and organizations.

Massachusetts Wraparound Fidelity Assessment System

Wraparound Provider Practice Analysis

Community Counseling of Bristol County- Attleboro



Fifth Edition: September 2014

Developed by MBHP in Collaboration with the Wraparound Evaluation and Research Team

Department of Psychiatry, University of Washington

Public Behavioral Health and Justice Policy

CBHI Children's Behavioral Health Initiative

MBHP Massachusetts Behavioral Health Partnership

LIST OF ACRONYMS

CANS	Child and Adolescent Needs and Strengths
CBHI	Children's Behavioral Health Initiative
CPT	Care Planning Team
CSA	Community Service Agency
FS&T	Family Support and Training
ICC	Intensive Care Coordination
ICM	Intensive Clinical Manager
IHBS	In-Home Behavioral Services
IHT	In-Home Therapy
PCC	Primary Care Clinician
SED	Severe Emotional Disturbance
TM	Therapeutic Mentoring

BACKGROUND

When the district court ruled in *Rosie D. v. Romney* that youth in Massachusetts were not receiving adequate behavioral health screenings, community-based care, or service coordination, work was begun to develop a remedial plan. The result is the CBHI, established as a means of strengthening, expanding and integrating state services into a comprehensive, community-based system of care for youth and families. The initiative is a collaborative effort of health care providers, consumers, advocacy groups, state agencies, managed care entities and other stakeholders.

Among the key components of the CBHI is the provision of *wraparound* care coordination for youth living with a serious emotional disturbance. During *wraparound*, a care coordinator affiliated with one of the state's 32 community service agencies works with the youth's family to convene a care planning team. Using the results of a comprehensive clinical assessment inclusive of the MA CANS, the team works together to develop an individual care plan and safety plan (and other Crisis Planning Tools chosen by the family) tailored to meet the youth's needs.

CBHI Mission

Strengthen, expand and integrate Massachusetts services into a comprehensive, community-based system of care so that families and their children with significant behavioral, emotional or mental health needs can obtain the services necessary for success in home, school and community.

Wraparound is not a form of treatment, but rather a process for coordinating service delivery for youth with complex needs. Intensive home and community-based services offered to youth and families engaged in *wraparound* include in-home therapy, in-home behavioral services, therapeutic mentoring, family support and training, and mobile crisis intervention.

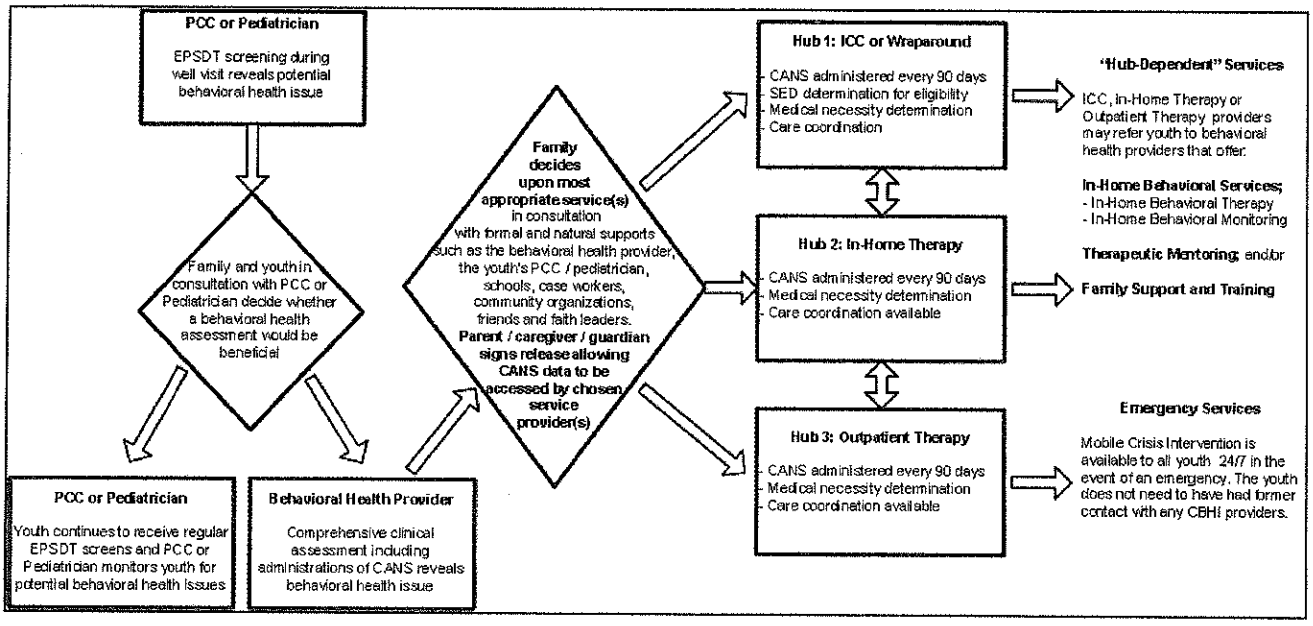


Figure 1: This diagram shows how youth access Wraparound services, from the initial behavioral health assessment (left), to an encounter with the "hub" service (middle), to referral for additional services (right).

Seven experimental and six quasi-experimental studies have compared outcomes of traditional interventions for youth to outcomes from interventions that incorporate *wraparound*. Two findings of particular importance to providers are that to be successful, *wraparound* programs must display *fidelity* and be targeted to youth who meet medical necessity.[1]

Typically we define *fidelity* as the degree to which a program is implemented as intended by its developers. Since *wraparound* wasn't developed by an individual or team – but rather through a collaborative process spearheaded by the National Wraparound Initiative (www.nwi.pdx.edu) – the definition of *wraparound fidelity* has been shaped by multiple individuals and organizations. In this analysis, wraparound fidelity is defined as the degree to which providers (a) adhere to the principles of quality wraparound and (b) carry out the basic activities of facilitating a wraparound process.

This document was developed as a tool for providers to gauge the degree to which their CSAs exhibit *wraparound fidelity* and to identify strengths and areas for improvement. The following pages summarize findings from the Massachusetts Wraparound Fidelity Assessment System (WFAS). This system encompasses the Wraparound Fidelity Assessment, Version 4 (MA WFI-4) and the Team Observation Measure (MA TOM).

[1] Bruns E, Leverentz-Brady K, Suter J. 2008. Is it Wraparound Yet? Setting Quality Standards for Implementation of the Wraparound Process. *Journal of Behavioral Health Services & Research* **35**(3): 240-252.

HOW TO USE THIS PROVIDER PRACTICE ANALYSIS

The Massachusetts Fidelity Assessment System was developed as a means for providers to monitor the fidelity of their Community Service Agencies to the principles and activities of Wraparound. Research shows that the attainment of high fidelity scores at the care team and program levels is associated with positive youth and family outcomes.[2] Fidelity monitoring also lays the groundwork for measuring the outcomes and efficiency of the Children's Behavioral Health Initiative over time.

This Wraparound Provider Practice Analysis is organized into four sections:

Section 1: Massachusetts Team Observation Measure Results (pp. 6 – 17)

Section 2: Massachusetts Wraparound Fidelity Index Results (pp. 18 – 24)

Section 3: Relative Strengths and Areas for Improvement (pp. 25 – 27)

Sections 1, 2 and 3 present customized results of the MA TOM and MA WFI-4 for **Community Counseling of Bristol County- Attleboro.** Each section begins with a summary of the methods by which the measure is administered and the items are scored. Findings are then presented in three ways, starting with broad summaries and then moving to more detailed analyses:

1. Total **Fidelity scores** are presented alongside the average Fidelity score for all CSAs ("state mean") and the average Fidelity score for all states that have participated in the TOM or WFI ("national mean");

2. **Principle scores** are presented for each of the 10 principles of Wraparound. These scores are presented alongside the average Principle score for all CSAs ("state mean") and the average Principle score for all states that have participated in the TOM or WFI ("national mean"); and

3. **Item scores** are presented for each of the items corresponding to the 10 principles of quality Wraparound. These scores are presented alongside the average Item scores for all CSAs ("state mean") and the average Item scores for all states that have participated in the TOM or WFI ("national mean.")

Until recently, CSA scores would have been difficult to interpret due to a lack of external criteria or norms against which to compare them. To overcome this barrier, the Wraparound Evaluation and Research Team compiled a national database of TOM and WFI data. This is what allows us to compare your CSA's scores to the national mean. National means were calculated by averaging scores across all TOMs and WFI-4 caregiver interviews completed outside of Massachusetts. The means were updated in FY 2012 to include observations and interviews completed between July 2009 and June 2012.

[2] Suter J, Bruns E. 2009. Effectiveness of the Wraparound Process for Children with Emotional and Behavioral Disorders: A Meta-Analysis. *Clinical Child and Family Psychology Review* **12**(4): 336-351.

The final section of the Wraparound Provider Practice Analysis contains a summary of the results from the MA TOM and MA WFI-4, including a listing of strengths and areas for improvement.

To read more about measuring wraparound fidelity, consider visiting the National Wraparound Initiative homepage and clicking on "assessment/fidelity": http://www.nwi.pdx.edu

To read more about psychometrics, reliability and validity of the WFI, go to http://depts.washington.edu/wrapeval/docs and download the document entitled "Psychometrics…" A study of the psychometrics, reliability and validity of the TOM is expected to be published in FY2013 and will be posted on the National Wraparound Initiative Web site.

Ten Principles of Wraparound

1. Family Voice and Choice
2. Team-Based
3. Natural Supports
4. Collaboration
5. Community-Based
6. Culturally Competent
7. Individualized
8. Strengths-Based
9. Unconditional
10. Outcome-based

For detailed information on the *Principles of Wraparound*, please see **Appendix A.**

CBHI Vision

A behavioral health care system where policies, financing, management and delivery of publicly-funded behavioral health services are integrated to make it easier for families to find and access appropriate services, and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

CBHI Values

- **Strengths-based:** Services are built on the strengths of family and their community.
- **Family-Driven, Youth-Guided:** Services are driven by the needs and preferences of the child and family, and are developed in partnership with and are accountable to families.
- **Culturally Responsive:** Services are responsive to the family's values, beliefs, norms, and to socioeconomic and cultural context.
- **Continuous Improvement:** Service improvements reflect a culture of continuous leaning, and are informed by data, family feedback, evidence and best practice.
- **Collaborative and Integrate:** Services are integrated across child-serving agencies and programs.

SECTION 1: MASSACHUSETTS TEAM OBSERVATION MEASURE (MA TOM)

Background from the NWI Resource Guide to Wraparound

The Massachusetts Team Observation Measure (MA TOM) assesses adherence to standards of high-quality wraparound during team meeting sessions. It was originally developed to be used by external evaluators, but has also been used by supervisors to help support coaching and supervision of wraparound staff. The MA TOM consists of 20 items, with two items dedicated to each of the 10 principles of wraparound. Each item consists of up to 4 indicators of high-quality wraparound practice as expressed during a child and family team meeting. Trained raters indicate whether or not each indicator was in evidence during the wraparound team meeting session. These ratings are translated into a score for each item as well as a total fidelity score for the session overall.

Interpreting MA TOM Scores

Your CSA's FY2010, FY2011, FY2012, FY2013, and FY2014 total fidelity, principle and item/indicator scores are displayed on the following pages with comparisons to the state and national averages. To arrive at a principle score, the two item scores corresponding to each principle were summed, resulting in a score ranging from 0 (low fidelity) to 8 (high fidelity). Principle scores were then expressed as a percent of total possible fidelity. A principle score of 7 out of 8, for example, would be expressed as 87.4% fidelity.

MA TOM items are comprised of up to 4 indicators (denoted by letters a through d) that the observer assigns a "yes" or a "no." For each TOM, item scores were calculated using the following logic model, which takes into account the fact that each item is made up of a different number of indicators. Overall item scores represent the average of item scores across all TOMs completed by your CSA:

Number of Indicators	Number of Indicators Scored 'Yes'	Item Score
4	4	4
	3	3
	2	2
	1	1
	0	0
3	3	4
	2	3
	1	1
	0	0
2	2	4
	1	2
	0	0
1	1	4
	0	0

Indicators corresponding to each item are displayed as a percent, interpreted as the percent of time the indicator was assigned a 'yes.'

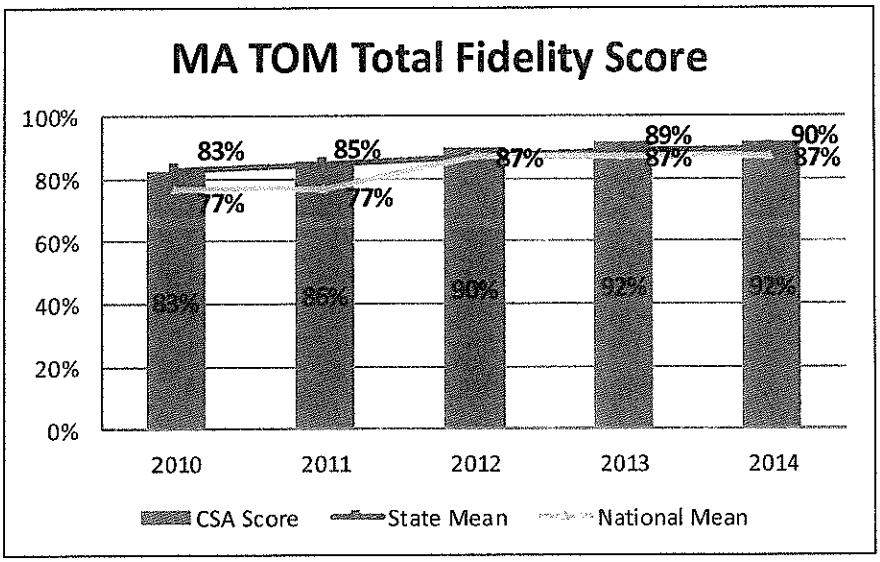
0	None of the indicators for this item were evident during the team meeting (i.e. none were scored 'yes')
1	Some, but fewer than half of the indicators for this item were scored 'yes'
2	About half of the indicators for this item were scored 'yes'
3	More than half, but not all, of the indicators for this item were scored 'yes'
4	All of the indicators for this item were evident during observation (i.e. all were scored 'yes')

Methods

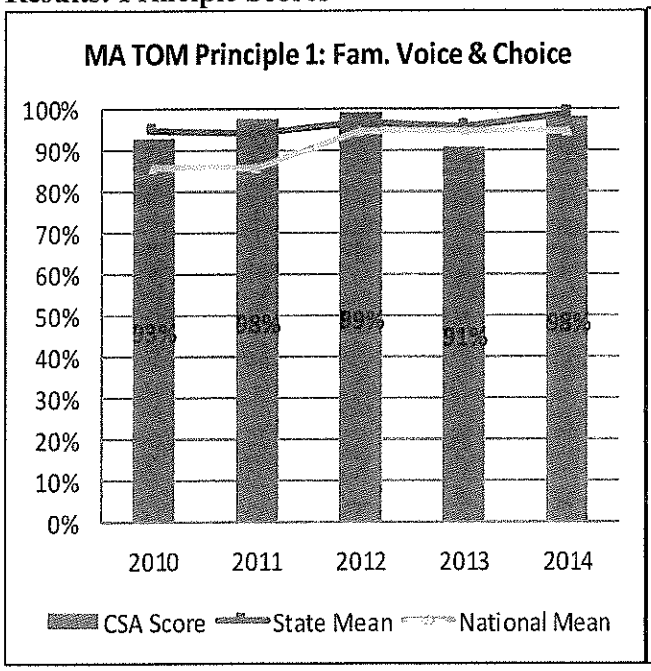
The MA TOM is one of two tools being used to monitor and evaluate (1) adherence to the principles of Wraparound, and (2) whether the basic activities of facilitating Wraparound are occurring. From July 1, 2013 through May 30, 2014, the MA TOM was administered by program supervisors during care team sessions led by intensive care coordinators (ICCs) carrying a caseload for four or more months. For existing ICCs, the requirement is that two TOMs be completed per year. For new ICCs, the requirement is that two TOMs be completed within months four and six from their date of hire. There were 717 TOM assessments completed and entered into WrapTrack in FY2014. This number includes 23 assessments from **Community Counseling of Bristol County- Attleboro.**

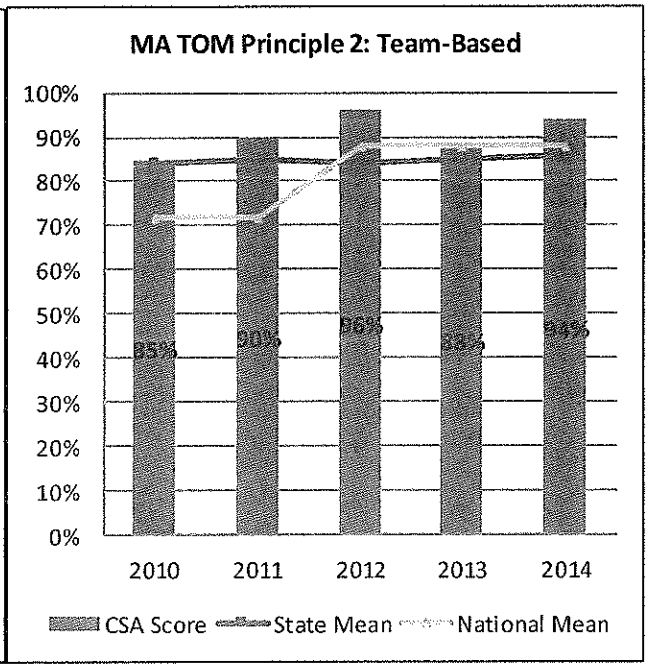
Results: FY2014 Total Fidelity and Item Scores

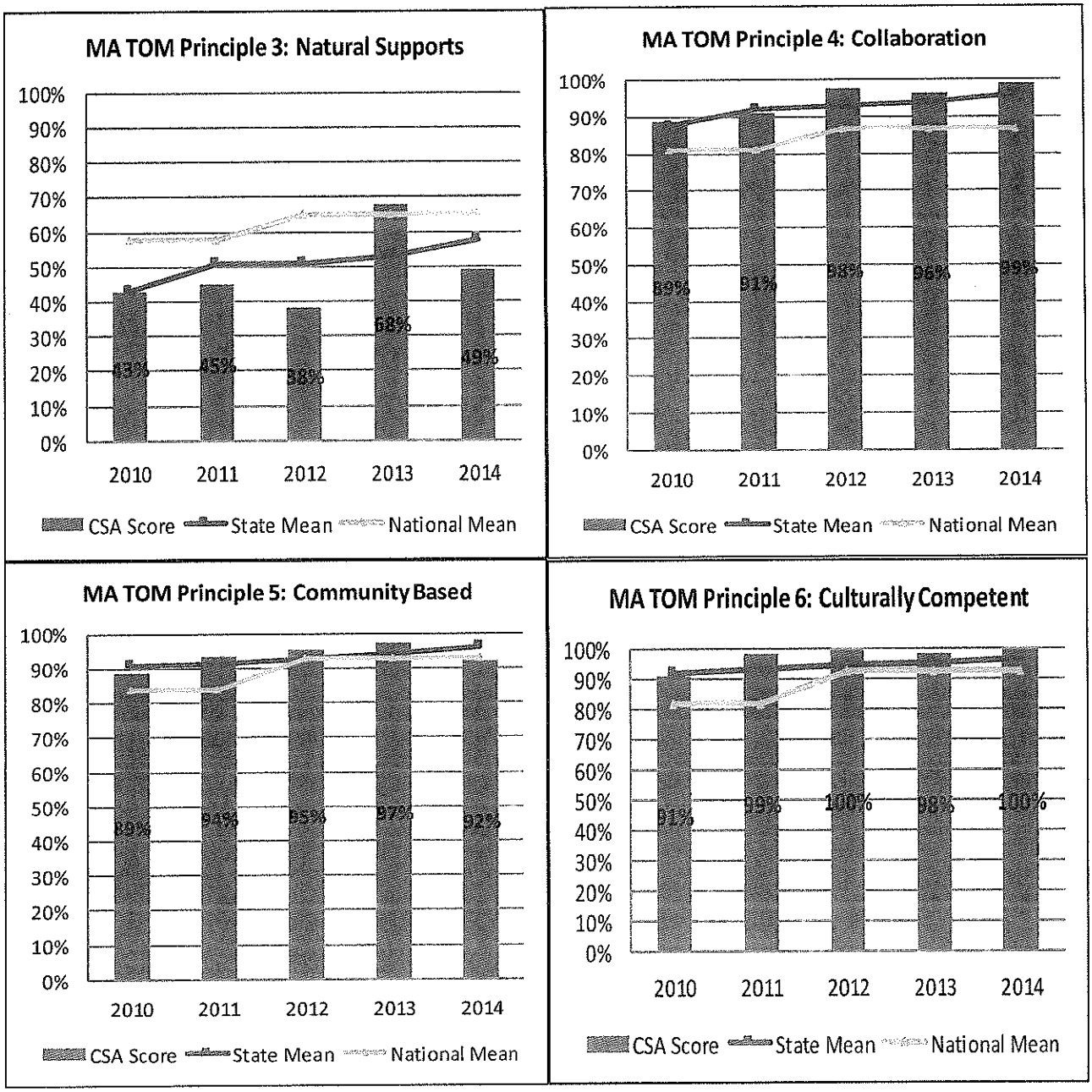
Item		CSA Score	State Mean	National Mean
1	Team Membership and Attendance	88%	76%	86%
2	Effective Team Process	100%	97%	91%
3	Facilitator Preparation	99%	95%	82%
4	Effective Decision Making	100%	97%	92%
5	Creative Brainstorming and Options	100%	94%	84%
6	Individualized Process	96%	97%	94%
7	Natural and Community Supports	38%	43%	47%
8	Natural Support Plans	60%	74%	83%
9	Team Mission and Plans	97%	94%	91%
10	Shared Responsibility	100%	98%	95%
11	Facilitation Skills	100%	96%	90%
12	Cultural and Linguistic Competence	100%	99%	96%
13	Outcomes-Based Practice	100%	91%	80%
14	Evaluating Process and Success	98%	92%	81%
15	Youth and Family Voice	99%	99%	98%
16	Youth and Family Choice	98%	98%	93%
17	Focus on Strengths	99%	95%	87%
18	Positive Team Culture	98%	97%	91%
18	Community Focus	85%	94%	89%
20	Least Restrictive Environment	99%	98%	98%
Total Fidelity Score: Average Fidelity score across TOMs (for CSAs and National Mean) or CSAs (for State Mean)		92%	90%	87%

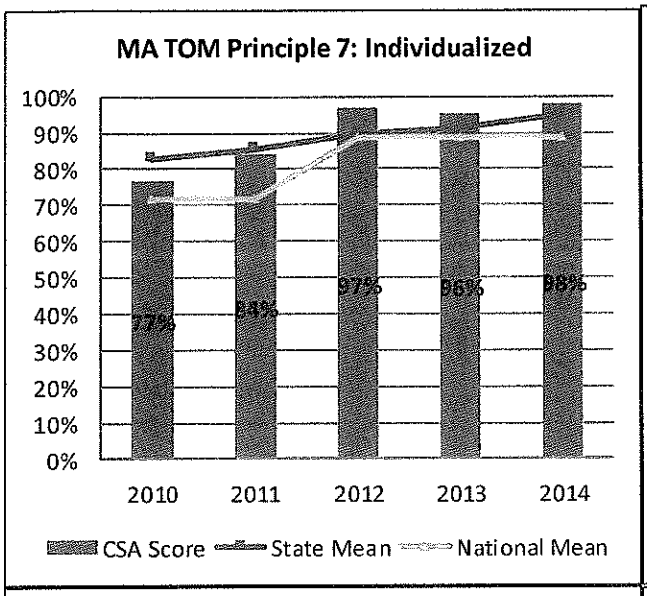


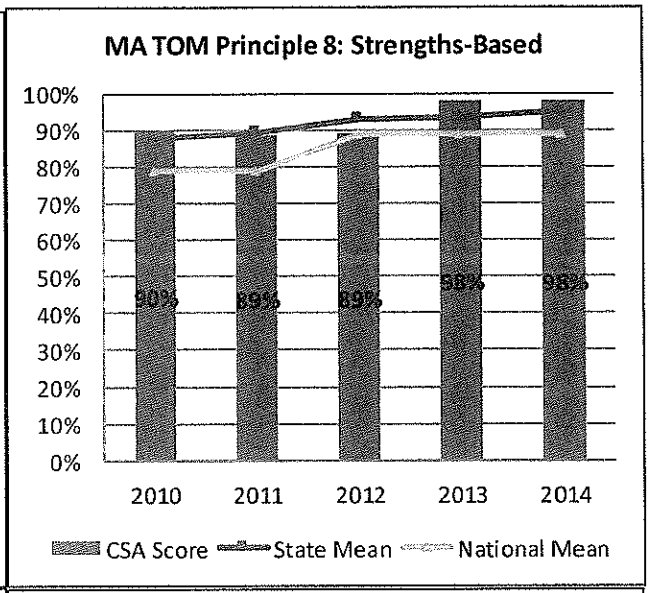
Results: Principle Scores

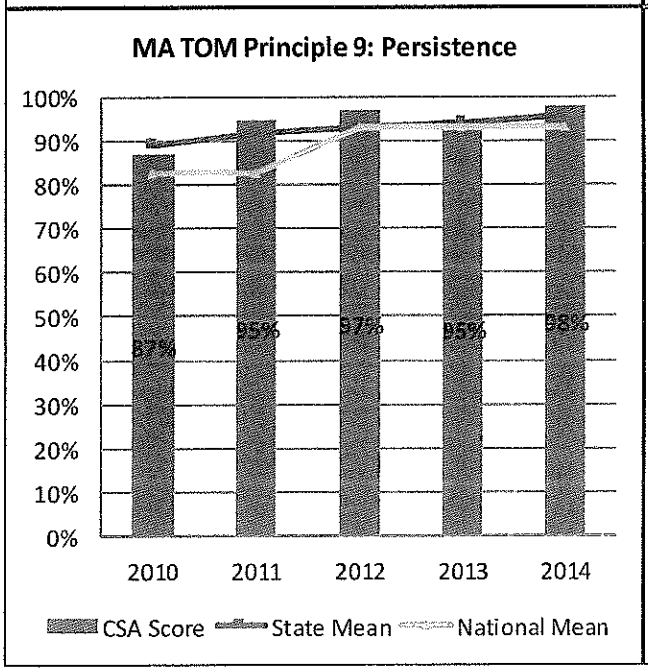


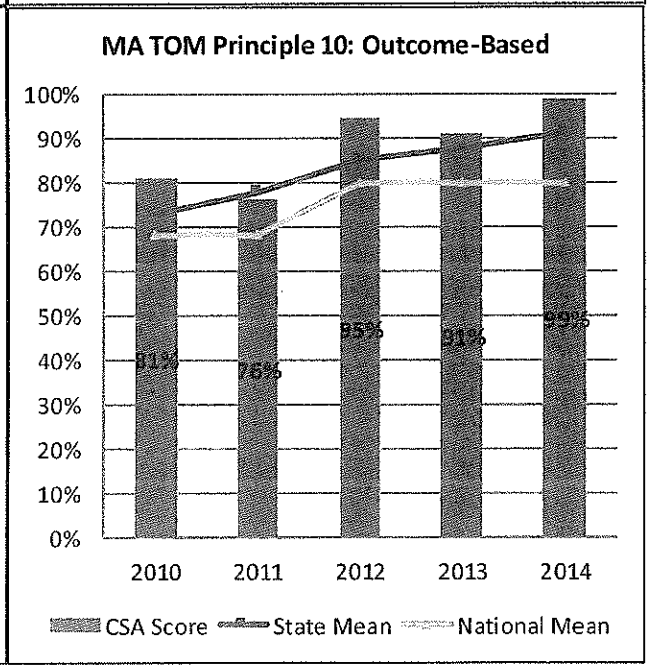



MA TOM Principle 3: Natural Supports
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
43%
45%
38%
68%
49%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA TOM Principle 4: Collaboration
89%
91%
98%
96%
99%
MA TOM Principle 5: Community Based
89%
94%
95%
97%
92%
MA TOM Principle 6: Culturally Competent
91%
99%
100%
98%
100%

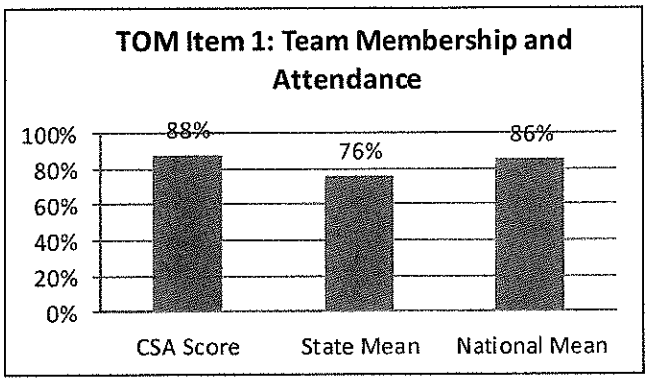

MA TOM Principle 7: Individualized
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
77%
84%
97%
96%
98%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA TOM Principle 8: Strengths-Based
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
90%
89%
89%
98%
98%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean

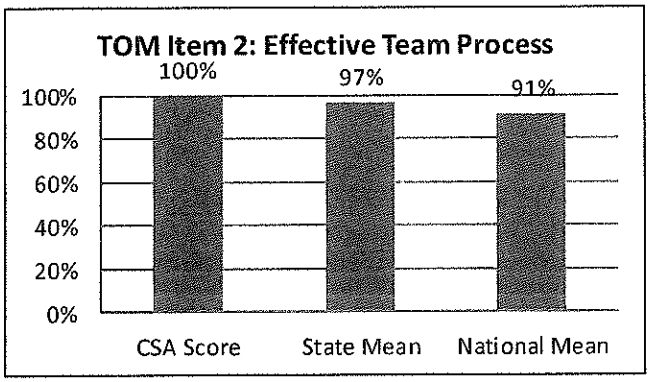

MA TOM Principle 9: Persistence
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
87%
95%
97%
95%
98%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA TOM Principle 10: Outcome-Based
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
81%
76%
95%
91%
99%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean

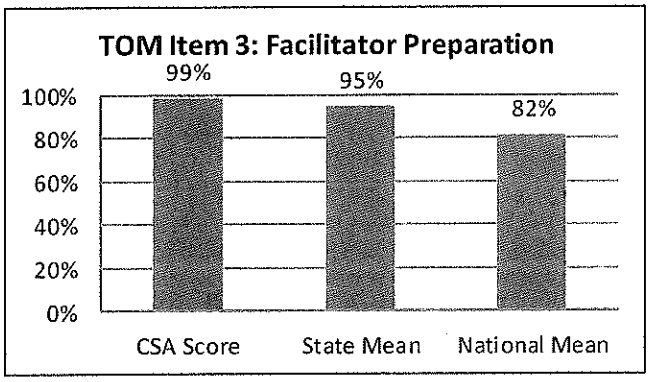
Results: FY2014 Item Scores



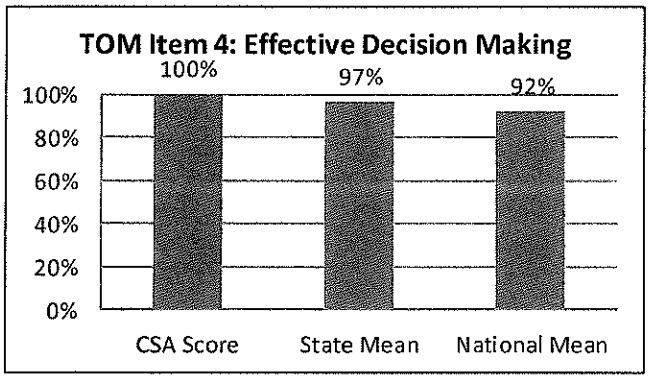
	Team Membership and Attendance	Mean score
		3.52
a	Parent/caregiver is a team member and present at meeting	100%
b	Youth (over age 9) is a team member and present at the meeting	77%
c	Key school and/or other public stakeholder agency representatives are present.	67%



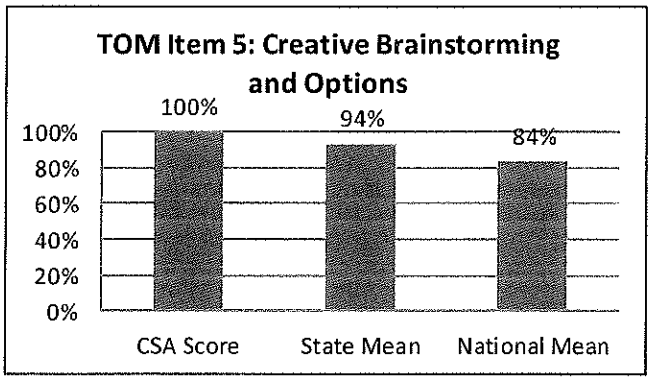
	Effective Team Process	Mean score
		4.00
a	Team meeting attendees are orientated to the wraparound process and understand the purpose of meeting	100%
b	The facilitator assists the team to review and prioritize family and youth needs	100%
c	Tasks and strategies are explicitly linked to goals	100%
d	Potential barriers to the nominated strategy or option are discussed and problem-solved	100%



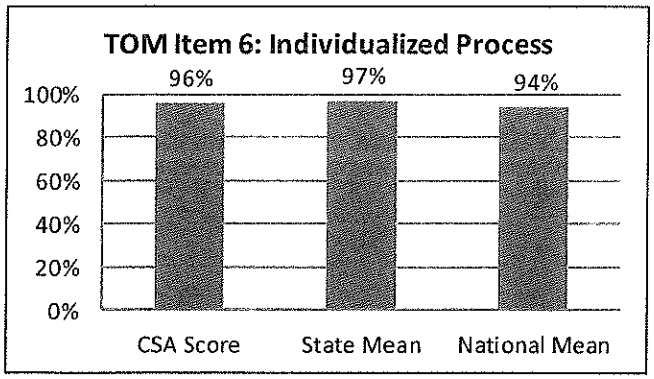
	Facilitator Preparation	Mean score
		3.96
a	There is a clear agenda or outline for the meeting, which provides an understanding of the overall purpose of meeting	100%
b	The meeting follows an agenda or outline such that team members know the purpose of their activities at a given time	100%
c	The facilitator has prepared needed documents and materials prior to the meeting	100%
d	A plan for the next meeting is presented, including time and date	95%



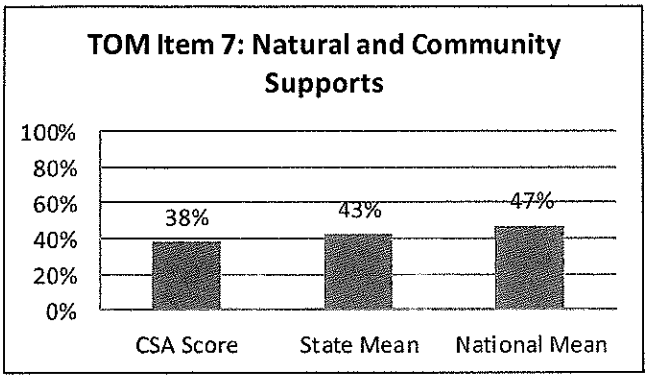
	Effective decision making	Mean score
		4.00
a	Team members demonstrate consistent willingness to compromise or explore further options when there is a disagreement	100%
b	Team members reach shared agreement after having solicited info from several members or having generated several ideas	100%
c	The plan of care is agreed upon by all present at the meeting	100%
d	The facilitator summarizes the content of the meeting at the end of the meeting, including next steps and responsibilities	100%



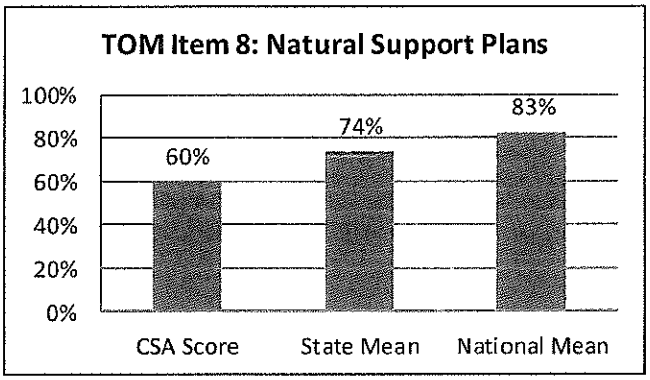
	Creative Brainstorming and Options	Mean score
		4.00
a	The team considers several different strategies for meeting each need and achieving each goal that is discussed	100%
b	The team considers multiple options for tasks or action steps.	100%
C	The facilitator leads a robust brainstorming process to develop multiple options to meet priority needs.	100%



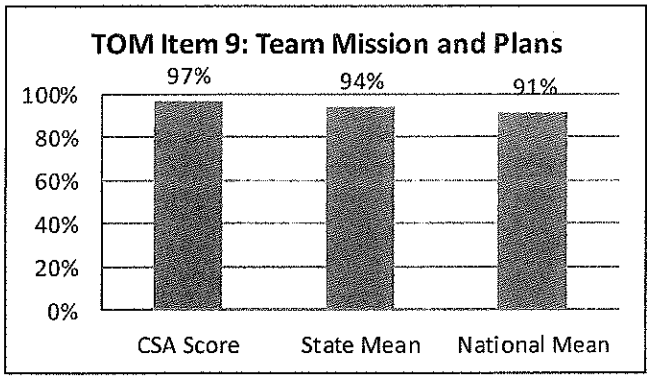
	Individualized process	Mean score
		3.83
a	Planning includes action steps or goals for other family members, not just identified child	91%
b	Facilitator and team members draw from knowledge about the community to generate strategies and action steps based on unique community supports	100%
c	Team facilitates the creation of individualized supports or services to meet the unique needs of child and/or family	96%
d	Youth, caregiver, and family members give their opinions about potential services, supports or strategies; including describing what has or has not worked in past	96%



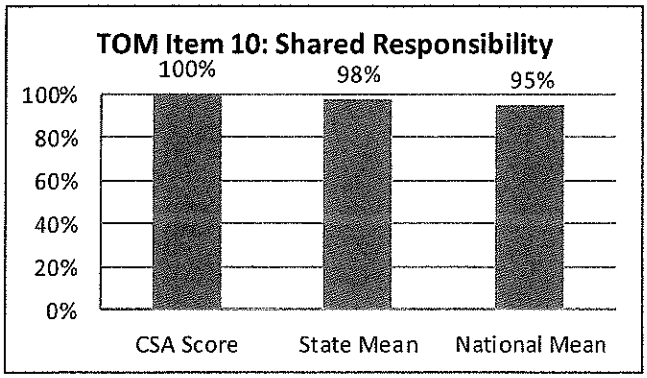
	Natural and community supports	Mean score
		1.52
a	Natural supports for the family are team members and present	26%
b	Team provides multiple opportunities for natural supports to participate in significant areas of discussion	69%
c	Community team members and natural supports participate in decision-making	42%
d	Community team members and natural supports have a clear role on the team	73%



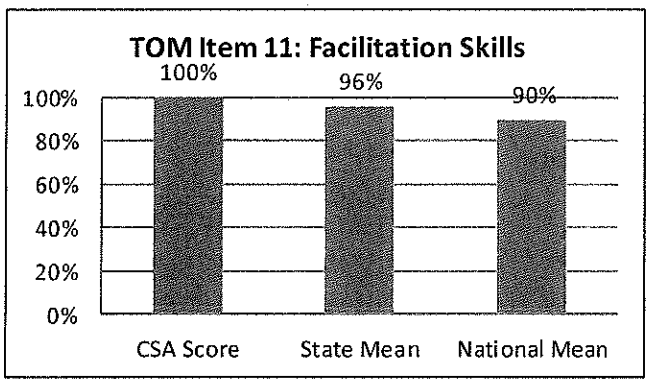
	Natural support plans	Mean score
		2.39
a	Brainstorming of options and strategies includes strategies to be implemented by natural and community supports	86%
b	The plan of care represents a balance between formal services and informal supports	43%
c	There is flexible funding available to the team to allow for creative services, supports and strategies	38%



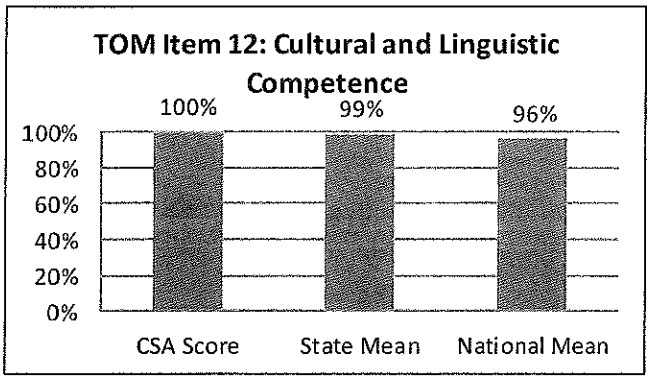
	Team mission and plans	Mean score
		3.87
a	The team discusses or has produced a mission/vision statement.	100%
b	The team creates or references a plan that guides its work	100%
c	The team has confirmed or is creating a crisis plan	87%
d	The team plan contains specific goals that are linked to strategies and action steps	100%



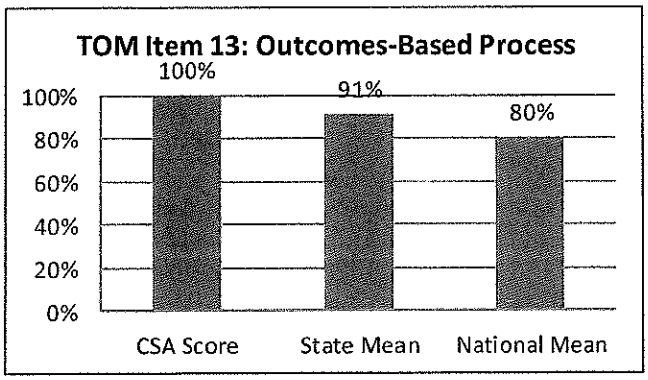
	Shared Responsibility	Mean score
		4.00
a	The team explicitly assigns responsibility for action steps that define who will do what, when and how often	100%
b	There is a clear understanding of who is responsible for action steps and follow up on strategies in the plan	100%
c	Providers and agency representatives at the meeting demonstrate that they are working for the family and not there to represent a different agenda or set of interests	100%



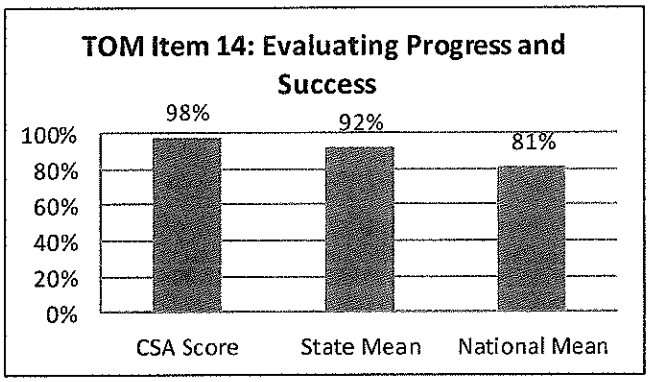
	Facilitation skills	Mean score
		4.00
a	Facilitator is able to impart understanding about what the wraparound process is, how it will work for this family, and how individual team members will participate	100%
b	Facilitator reflects, summarizes, and makes process-orientated comments	100%
c	Facilitator is able to manage disagreement and conflict and elicit underlying interests, needs, and motivations of team members	100%
d	Talk is well distributed across team members and each team member makes an extended or important contribution	100%



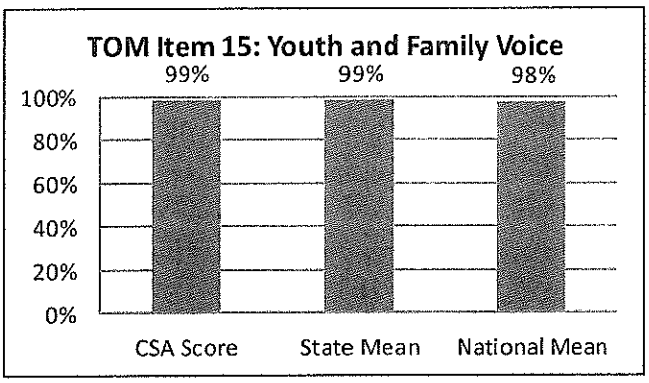
	Cultural and Linguistic Competence	Mean score
		4.00
a	The youth, caregiver, and family members are given time to talk about the family's values, beliefs, and traditions	100%
b	The team demonstrates a clear and strong sense of respect for the family's values, beliefs, and traditions	100%
c	Meetings and meeting materials are provided in the language the family is most comfortable with	100%
d	Members of the team use language the family can understand (i.e. no professional jargon or acronyms)	100%



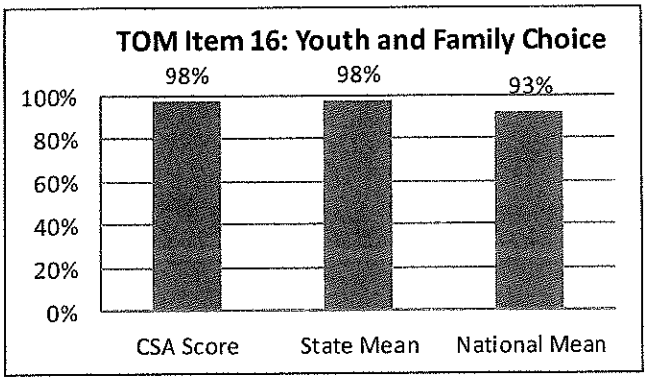
	Outcomes Based Process	Mean score
		4.00
a	The team uses objective measurement strategies	100%
b	The team assesses goals/strategies using measures of progress	100%
c	The team revises the plan if progress toward goals is not evident.	100%



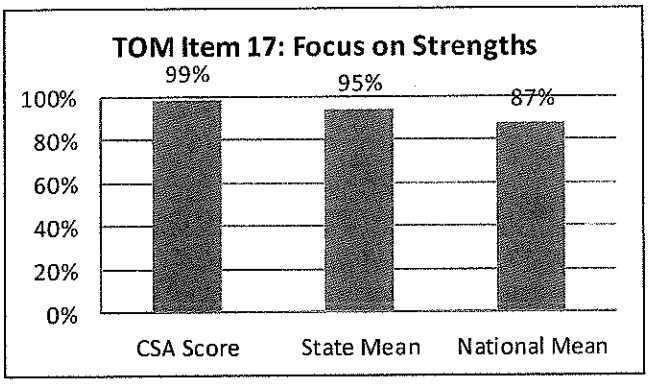
	Evaluating Progress and Success	Mean score
		3.91
a	The team conduces a systematic review of members' progress on assigned action steps	100%
b	The facilitator checks in with the team members about their comfort and satisfaction with the team process,	95%
c	Objective or verifiable data is used as evidence of success, progress, or lack thereof.	95%



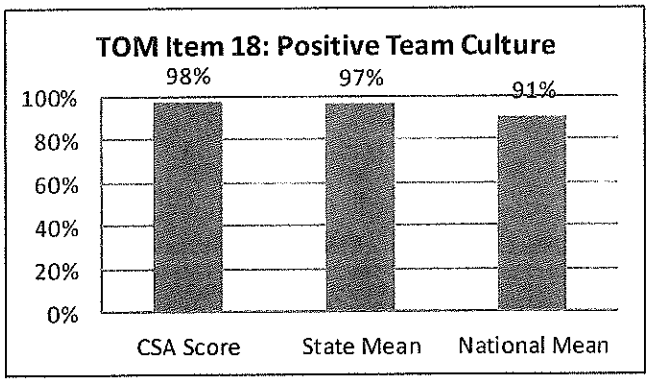
	Youth and Family Voice	Mean score
		3.96
a	The team provides extra opportunity for caregivers to speak and offer opinions, especially during decision making	100%
b	The team provides extra opportunity for the youth to speak and offer opinions, especially during decision making	100%
c	Caregivers, parents, and family members are afforded opportunities to speak in an open-ended way about current and past experiences and/or about hopes for the future	100%
d	The youth is invited to speak in an open-ended way about current and past experiences and/or about hopes for the future	92%



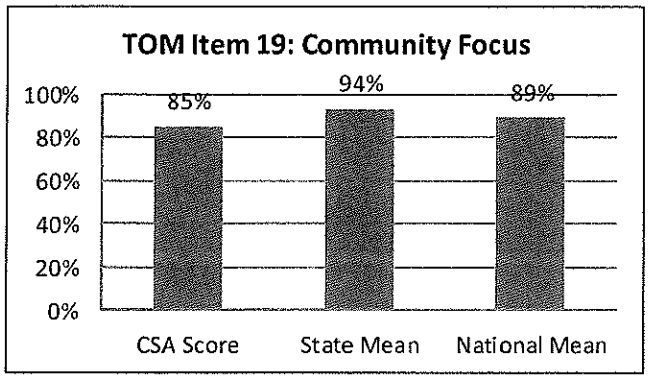
	Youth and Family Choice	Mean score
		3.91
a	The youth prioritizes life domains, goals, or needs on which she or he would like the team to work	92%
b	The caregiver or parent prioritizes life domains goals, or needs on which he or she would like the team to work.	100%
c	The family and youth have highest priority in decision making	96%



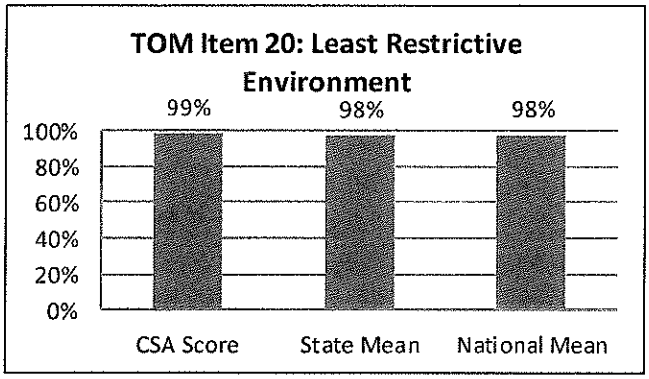
	Focus on Strengths	Mean score
		3.96
a	Team members acknowledge or list caregiver/youth strengths	100%
b	Team builds an understanding of how youth strengths contribute to the success of team missions or goals	100%
c	In designing strategies, team members consider and build on strengths of the youth and family	100%
d	Facilitator and team members analyze youth and family member perspectives and stories to identify functional strengths	96%



	Positive Team Culture	Mean score
		3.91
a	The team focuses on improvements or accomplishments throughout the meeting	100%
b	The facilitator directs a process that prevents blame or excessive focus on or discussion of negative events	96%
c	The facilitator encourages team culture by celebrating successes since the last meeting	100%
d	There is a sense of openness and trust among team members	96%



	Community Focus	Mean score
		3.41
a	The team is actively brainstorming and facilitating community activities for the youth and family	90%
b	The team prioritizes services that are community-based	77%
c	The team prioritizes access to services that are easily accessible to the youth and family	90%



	Least Restrictive Environment	Mean score
		3.96
a	The team's mission and/or identified needs support the youth's integration into the least restrictive residential and educational environments possible	100%
b	When residential placements are discussed, team chooses community placements for the child or youth rather than out-of-community placements, wherever possible.	80%
c	Serious challenges are discussed in terms of finding solutions, not placement in more restrictive residential or educational environments	100%

SECTION 2: MASSACHUSETTS WRAPAROUND FIDELITY INDEX, VERSION 4

Background from the NWI Resource Guide to Wraparound

The Massachusetts Wraparound Fidelity Index, Version 4 (MA WFI-4) is an interview that measures the nature of the wraparound process that an individual family received. The MA WFI-4 is completed through brief, confidential telephone interviews administered by staff of the consumer-led non-profit Consumer Quality Initiatives to caregivers of youth participating in Wraparound who have signed release of information forms. A demographic form is also part of the WFI-4. The WFI-4 interviews are organized by the four phases of the wraparound process. In addition, the 40 items of the WFI interview are keyed to the 10 principles of the wraparound process, with 4 items dedicated to each principle. In this way, the WFI-4 interviews are intended to assess adherence to the basic wraparound practice model, as well as fidelity to the principles of wraparound. WFI data can be used to assess the overall fidelity of an organization or wraparound initiative. Data can also be analyzed by phase, principle or item to help a program or supervisor make mid-course corrections.

Interpreting WFI Scores

Your CSA's FY2010, FY2011, FY2012, FY2013, and FY2014 total fidelity scores, principle and item scores are displayed on the following pages with comparisons to the state and national averages. To arrive at a total Principle score, the four item scores for each Principle were summed, resulting in a score ranging from 0 (low fidelity) to 8 (high fidelity). Principle scores were then expressed as a percent of total possible fidelity; a Principle score of 7 out of 8, for example, would be expressed as 87.4% fidelity.

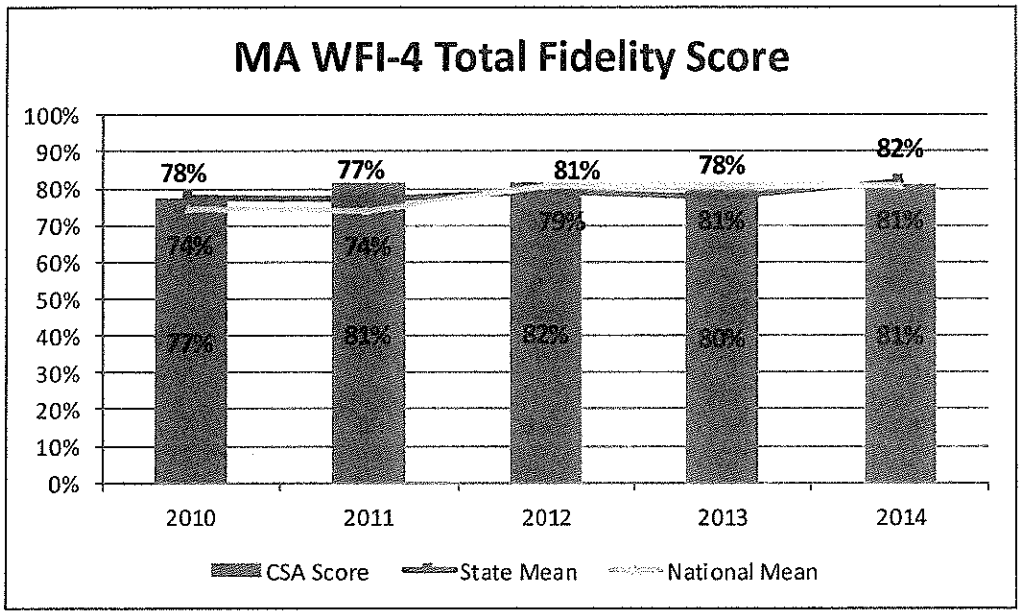
MA WFI-4 respondent forms include 40 items, corresponding to four items per Wraparound principle. For each item, caregivers' answers from the WFI interview were coded as "yes" (high fidelity), "somewhat or sometimes" (partial fidelity) or "no" (low fidelity). Item responses, which are presented on pp. 22-24, were then scored by the interviewer on a scale from 0 (low fidelity) to 2 (high fidelity).

When scoring the WFI, interviewers from CQI had to keep in mind that items are reverse-coded. For example, a "yes" response on a standard item (e.g., "Before your first team meeting, did your wraparound facilitator fully explain how the wraparound process would work?") would be scored a 2, indicating good Wraparound fidelity. However, a "yes" response to a reverse-coded item (e.g., "Is it difficult to get team members to attend team meetings when they are needed?") would receive a 0.

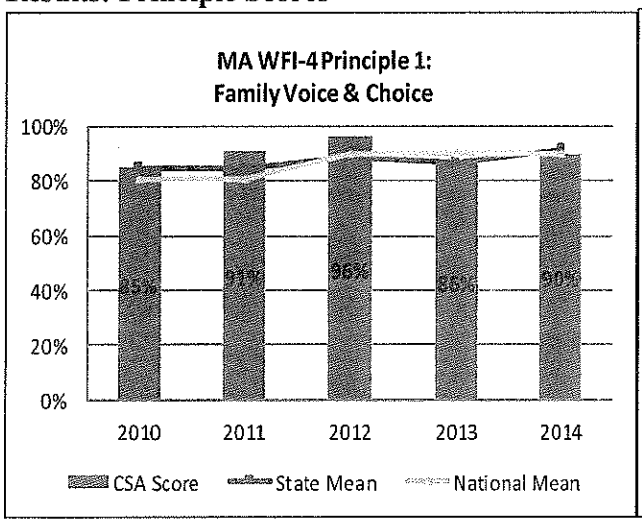
Methods

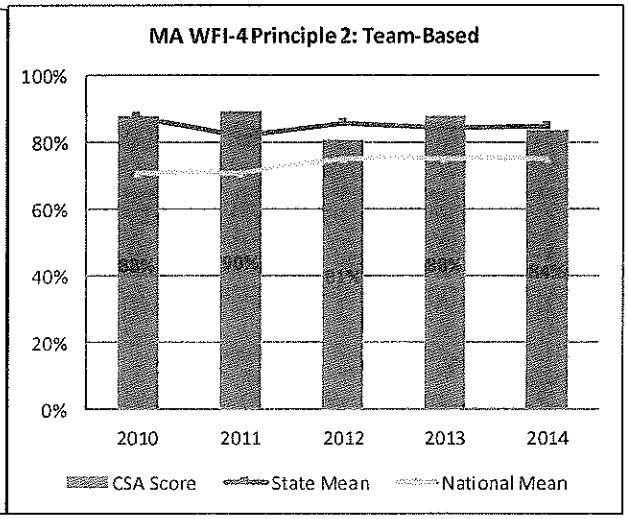
The Massachusetts Wraparound Fidelity Index, Version 4 (MA WFI-4) is one of two tools being used to monitor and evaluate (1) adherence to the principles of Wraparound, and (2) whether the basic activities of facilitating Wraparound are occurring. The MA WFI-4 was administered by staff of Consumer Quality Initiatives (CQI) from September 2013 through June 2014. During this time CQI interviewed caregivers of youth who enrolled in wraparound from January through December 2013, and who signed release of information forms. (Note that no caregivers interviewed for the MA WFI-4 FY2013 were re-interviewed). The requirement was that 20 WFI interviews be completed for each CSA – provided there were enough youth enrolled and, consequently, an adequate number of release forms. On June 30, the end of the data collection period, 629 MA WFI-4 assessments had been completed and entered into the online data and reporting system, WrapTrack. This number includes 20 interviews with caregivers of youth participating in Wraparound at **Community Counseling of Bristol County- Attleboro.**

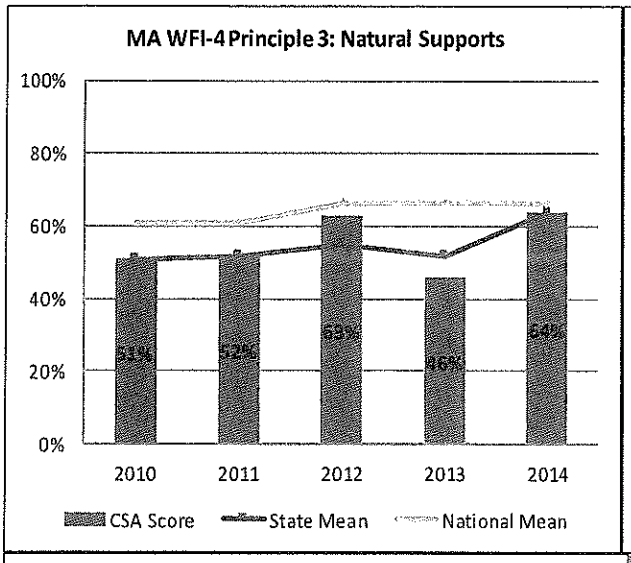
Results: Total Fidelity Score

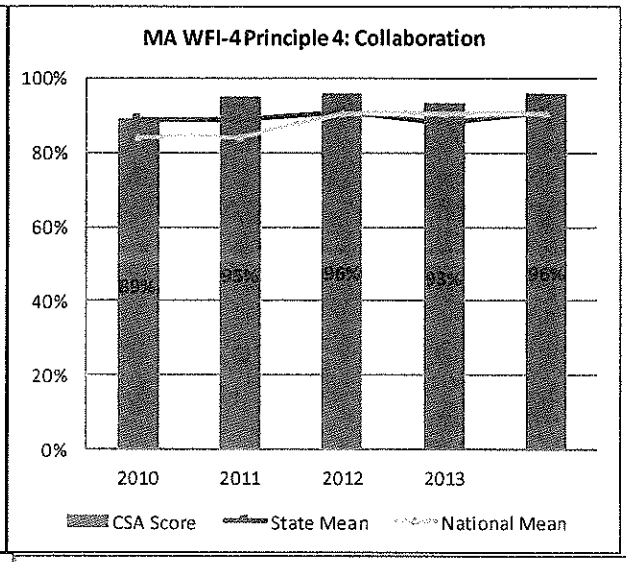


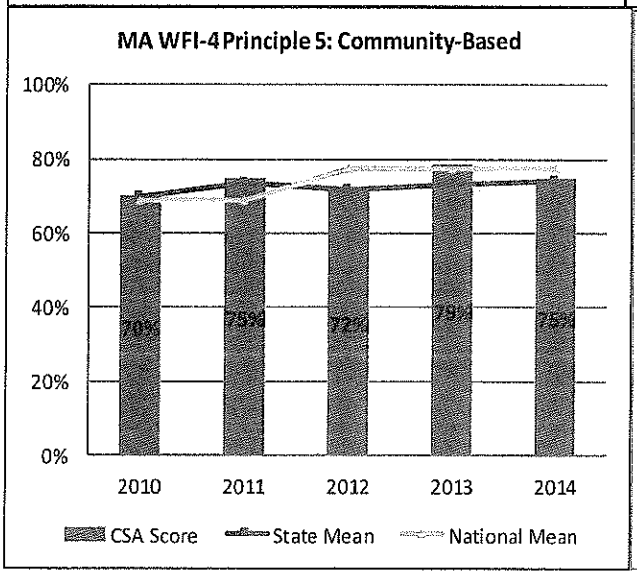
Results: Principle Scores

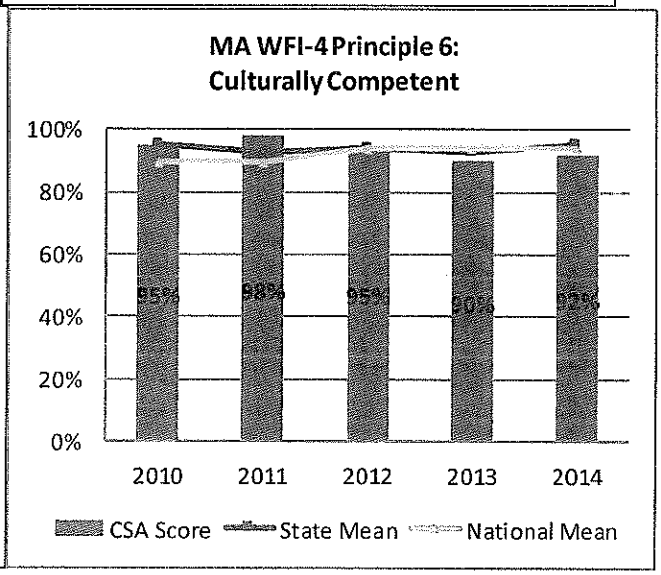




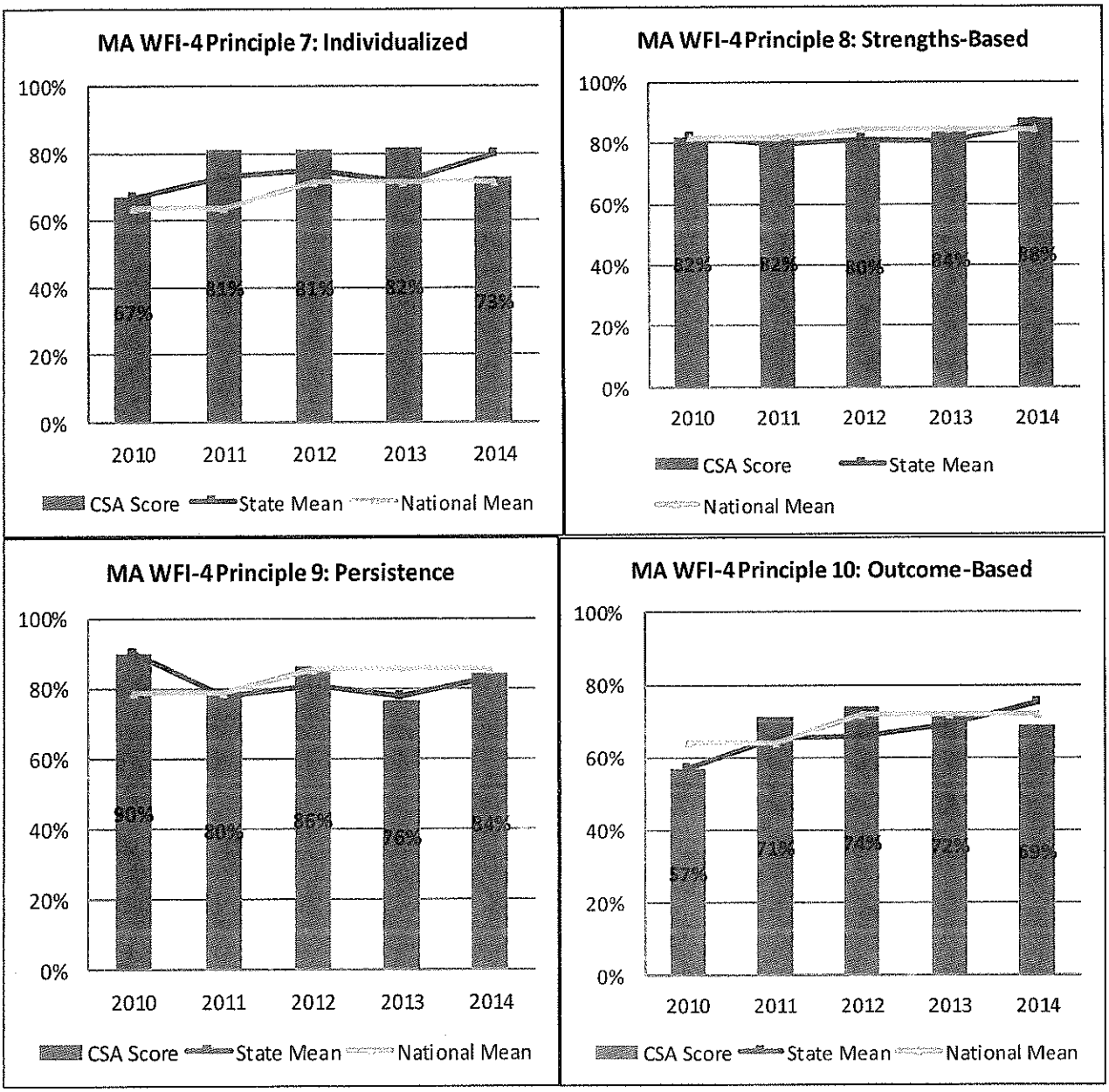

MA WFI-4 Principle 3: Natural Supports
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA WFI-4 Principle 4: Collaboration
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
CSA Score
State Mean
National Mean


MA WFI-4 Principle 5: Community-Based
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA WFI-4 Principle 6:
Culturally Competent
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean

[20]


MA WFI-4 Principle 7: Individualized
100%
80%
60%
40%
20%
0%
67%
81%
81%
82%
73%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA WFI-4 Principle 8: Strengths-Based
100%
80%
60%
40%
20%
0%
82%
82%
80%
84%
88%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA WFI-4 Principle 9: Persistence
100%
80%
60%
40%
20%
0%
90%
80%
86%
76%
84%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA WFI-4 Principle 10: Outcome-Based
100%
80%
60%
40%
20%
0%
57%
71%
74%
72%
69%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean

Results: FY 2014 Item Scores

WFI Item		CSA Score	National Mean	National SD	State Mean	State SD
1.1 (CC)	When you first met with the family, were they given ample time to talk about their strengths, beliefs, and traditions?	1.68	1.82	0.50	1.85	0.10
1.2 (FVC)	Before the first team meeting, did you fully explain the wraparound process and the choices the family could make?	1.84	1.83	0.51	1.92	0.07
1.3 (SB)	At the beginning of the wraparound process, was the family given an opportunity to tell you what things have worked in the past for the child and family?	1.95	1.81	0.53	1.91	0.08
1.4 (TB)	Did the family members select the people who would be on their wraparound team?	1.45	0.93	0.95	1.40	0.26
1.5 (TB)	Is it difficult to get team members to attend team meetings when they are needed?	1.85	1.64	0.66	1.74	0.14
1.6 (OB)	Before the first wraparound team meeting, did you go through a process of identifying what leads to crises or dangerous situations for the child and family?	1.63	1.76	0.61	1.91	0.10
2.1 (Col)	Did the family plan and its team create a written plan of care (or wraparound plan, child and family plan) that describes how the team will meet the child's and family's needs?	2.00	1.78	0.53	1.93	0.08
2.2 (TB)	Did the team develop any kind of written statement about what the future will look like for the child and family, or what the team will achieve for the child and family?	1.60	1.63	0.69	1.78	0.16
2.3 (Ind)	Can you summarize the services, supports, and strategies that are in the family's wraparound plan?	0.80	0.74	0.84	1.25	0.26
2.4 (SB)	Are the supports and services in the wraparound plan connected to the strengths and abilities of the child and family?	1.95	1.85	0.45	1.85	0.10
2.5 (CB)	Does the wraparound plan include strategies for helping the child get involved with activities in her or his community?	1.35	1.27	0.83	1.39	0.20
2.6 (Col)	Are there members of the wraparound team who do not have a role in implementing the plan?	1.80	1.78	0.57	1.78	0.14

2.7 (Col)	Does the team brainstorm many strategies to address the family's needs before selecting one?	1.85	1.84	0.49	1.83	0.14
2.8 (Ind)	Is there a crisis or safety plan that specifies what everyone must do to respond to a crisis?	1.72	1.67	0.68	1.75	0.13
2.9 (CB)	Do you feel confident that, in the event of a major crisis, the team can keep the child or youth in the community?	1.58	1.74	0.60	1.71	0.15
2.10 (FVC)	Would you say that people other than the family have higher priority than the family in designing their wraparound plan?	1.85	1.71	0.66	1.87	0.12
2.11 (CC)	During the planning process, did the team take enough time to understand the family's values and beliefs?	1.74	1.85	0.45	1.85	0.12
3.1 (FVC)	Are important decisions ever made about the child or family when they are not there?	1.70	1.77	0.58	1.88	0.10
3.2 (Ind)	When the wraparound team has a good idea for a support or service for the child, can it find the resources or figure out some way to make it happen?	1.80	1.82	0.49	1.76	0.14
3.3 (SB)	Does the wraparound team get the child involved with activities she or he likes and does well?	1.25	1.18	0.86	1.25	0.24
3.4 (NS)	Does the team find ways to increase the support the family gets from its friends and family members?	1.53	1.43	0.83	1.49	0.21
3.5 (Col)	Do the members of the team hold each another responsible for doing their part of the wraparound plan?	2.00	1.84	0.48	1.80	0.13
3.6 (NS)	Is there a friend or advocate of the child or family who actively participates on the wraparound team?	1.00	0.96	0.96	0.93	0.22
3.7 (Per)	Does the team come up with new ideas for the wraparound plan whenever the family's needs change?	1.90	1.85	0.46	1.82	0.12
3.8 (CB)	Are the services and supports in the wraparound plan difficult for the family to access?	1.84	1.72	0.61	1.64	0.12
3.9 (OB)	Does the team assign specific tasks to all team members at the end of each meeting?	1.55	1.73	0.62	1.77	0.23
3.10 (CC)	Do members of the team always use language the family can understand?	2.00	1.93	0.31	1.96	0.10

3.11 (SB)	Does the team create a positive atmosphere around successes and accomplishments at each team meeting?	1.95	1.92	0.33	1.92	0.09
3.12 (TB)	Does the team go out of its way to make sure that all team members – including friends, family, and natural supports – present ideas and participate in decision making?	1.80	1.85	0.46	1.88	0.10
3.13 (Per)	Do you think the wraparound process could be discontinued before the family is ready for it to end?	1.42	1.54	0.76	1.36	0.16
3.14 (CC)	Do all the members of the team demonstrate respect for the family?	1.90	1.94	0.30	1.90	0.09
3.15 (FVC)	Does the child or youth have the opportunity to communicate his or her own ideas when the time comes to make decisions?	1.84	1.91	0.34	1.60	0.18
4.1 (OB)	Has the team discussed a plan for how the wraparound process will end?	1.05	0.80	0.88	1.01	0.23
4.2 (NS)	Has the wraparound process helped the child develop friendships with other youth who will have a positive influence on him or her?	1.11	1.27	0.86	1.22	0.29
4.3 (OB)	Has the wraparound process helped the child to solve her or his own problems?	1.25	1.46	0.71	1.31	0.18
4.4 (Ind)	Has the team helped the child or youth prepare for major transitions?	1.60	1.50	0.78	1.64	0.22
4.5 (Per)	After formal wraparound has ended, do you think that the process will be able to be "re-started" if the youth or family needs it?	1.89	1.76	0.59	1.86	0.11
4.6 (NS)	Has the wraparound process helped the family to develop or strengthen relationships that will support them when wraparound is finished?	1.45	1.65	0.66	1.48	0.18
4.7 (CB)	Do you feel like the child and family will be able to succeed without the formal wraparound process?	1.21	1.49	0.77	1.22	0.27
4.8 (Per)	Will some members of the team be there to support the family when formal wraparound is finished?	1.47	1.68	0.65	1.62	0.19

SECTION 3: RELATIVE STRENGTHS AND AREAS FOR IMPROVEMENT

TOM and WFI Items: Relative Strengths

TOM and WFI Items: Areas for Improvement

Two Strongest Principles Overall (TOM and WFI)*

Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

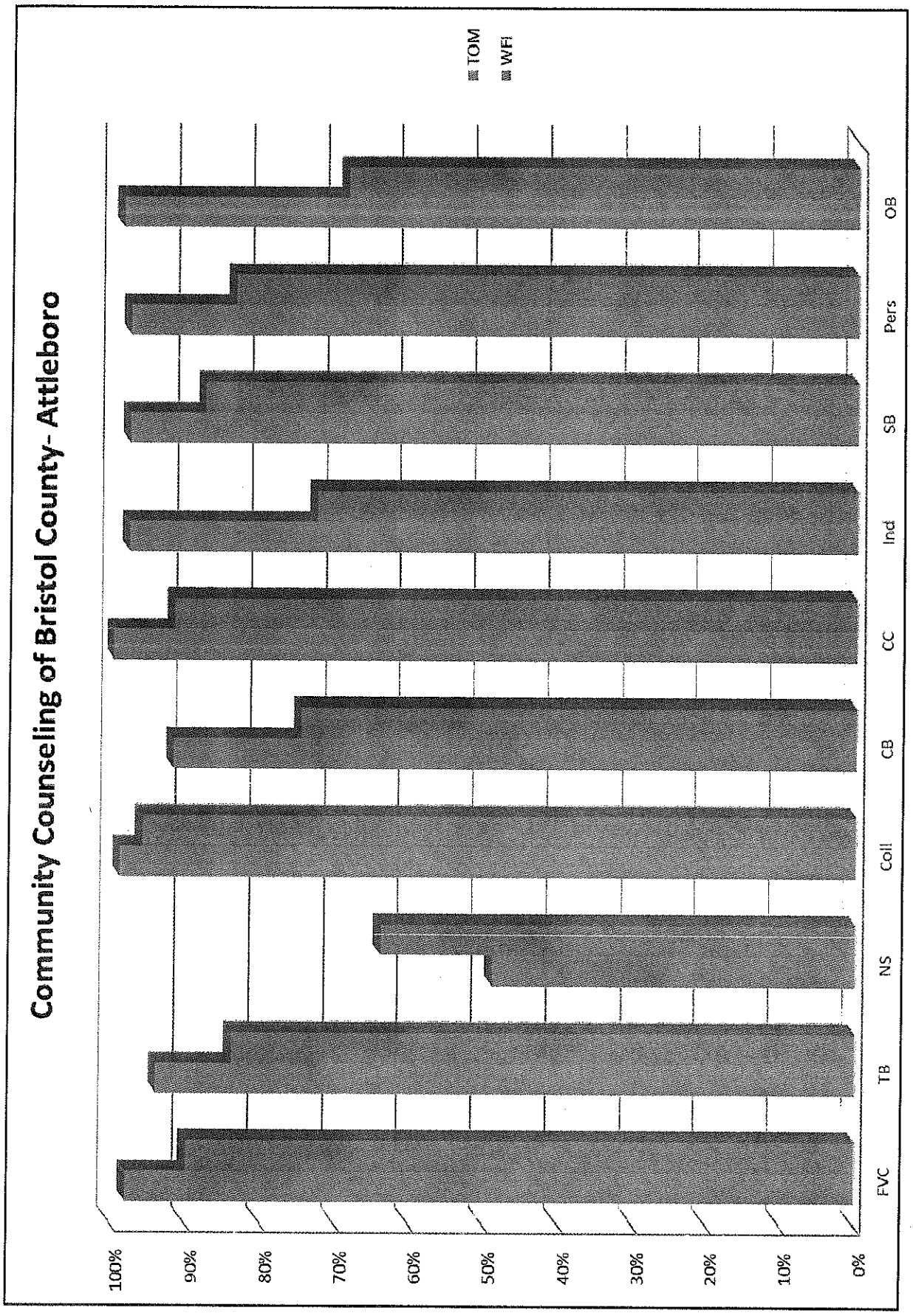
Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

Two Weakest Principles Overall (TOM and WFI)*

Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

* For descriptions of each principle, please see the attached *Ten Principles of the Wraparound Process* published by the NWI, Research and Training Center on Family Support and Children's Mental Health, Portland State University.


Community Counseling of Bristol County- Attleboro
TOM
WFI
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
FVC
TB
NS
Coll
CB
CC
Ind
SB
Pers
OB

[26]

TOM and WFI: Linking Principles to Items

Principle	Corresponding Items on TOM	Corresponding Items on WFI
1: Family Voice & Choice	15, 16	1.2, 2.10, 3.1, 3.15
2: Team-Based	1, 2	1.4, 1.5, 2.2, 3.12
3: Natural Supports	7, 8	3.4, 3.6, 4.2, 4.6
4: Collaboration	3, 4	2.1, 2.6, 2.7, 3.5
5: Community-Based	19, 20	2.5, 2.9, 3.8, 4.7
6: Culturally Competent	11, 12	1.1, 2.11, 3.10, 3.14
7: Individualized	5, 6	2.3, 2.8, 3.2, 4.4
8: Strengths-Based	17, 18	1.3, 2.4, 3.3, 3.11
9: Unconditional	9, 10	3.7, 3.13, 4.5, 4.8
10: Outcome-Based	13, 14	1.6, 3.9, 4.1, 4.3

3.5.3.7.1 – 3.5.3.7.2

Resumes from staff at director-level positions that have 5+ years of experience providing behavioral health services to youth and families and would be involved in MCI

Job descriptions of identified staff members who would be staffing MCI in any capacity

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **104 Supervising Professional**

Position Title: MCI Program Manager

Program Name: Mobile Crisis Intervention

Service Type: Emergency Services

Accountability: ESP Program Director

Summary of Position:

The MCI Program Manager is responsible for the overall supervision of the Clinician/Mobile Crisis Intervention Specialists and Family Partners. The MCI Program Manager maintains oversight of the program, including, but not limited, to crisis evaluation calls, evaluations, evaluation dispositions, seven-day intervention periods for youth remaining in the community, clinical appropriateness of brief solution-focused interventions, and program collaboration with collateral contacts. Data streams will include time from call to community response and location of service.

Education/Training:

- Must have at least five (5) years post-graduate experience providing behavioral health services to youth and families.
- Independently Licensed Master's Level Clinician.
- Must have at least three (3) years of supervisory and/or management experience.
- Excellent assessment and differential diagnostic skills.

Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, and potential safety issues.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.
- Must be able to articulate and promote a recovery orientation that is resolution focused, strengths-based, and culturally competent.
- Ability to manage resources including the hiring and retention of culturally competent staff.

- Possess knowledge and practice skills regarding Continuous Quality Improvement.
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties as well as the written skills required to manage an electronic health record system.

Responsibilities:

- Weekly 1 hour supervision with Intake Supervisor and Clinical Supervisors.
- Triage consultation/supervision as needed to staff.
- Formal written tracking of supervisory sessions.
- Participation in quarterly meetings with MCEs.
- Hire and orient new staff.
- Create and maintain on-call schedule.
- Maintain ongoing relationships with MCEs and referral sources.
- Track weekly productivity of all staff and update deficits monthly.
- Track financial and referral data and provide updates to administration as requested.
- Supervise and implement disciplinary actions as needed.
- Plan annual trainings in accordance with identified core competencies and MCE training requirements.
- Supervise billing administrator and provide back-up for billing functions as needed.
- Facilitate weekly staff meeting.
- Facilitate Clinicians peer supervision meetings.
- Input all new clients and update authorizations into database system and manage error reports.
- Complete staff employee evaluations annually.

List Other Job Requirements:

Knowledge of Core-Competencies as identified by the employee's assigned department. Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

The noise level in the office / facility is usually quiet, but can be loud due to client participation and groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

ESP RFR Attachment 3.5.3.7.2

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **104 Supervising Professional**

Position Title: MCI Clinical Supervisor

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: MCI Program Manager

Summary of Position:

Provide clinical supervision to staff, and also provide clinical services to children, adolescents, and their families.

Education/Training:

- Master's degree in a human services related discipline.
- Licensed as an LICSW, LMFT, or LMHC by the Commonwealth of Massachusetts.

Qualifications/Experience Requirements:

- Five (5) or more years of experience (post-licensure) in a human service position with at least two years of child-services-related supervisory experience.
- Must possess good organizational skills, effective written and verbal skills, and have experience with an electronic health record (EHR).
- Must possess clinical core competencies and experience regarding crisis assessment, intervention and stabilization strategies for children, adolescents, and families.
- Experience providing mobile crisis intervention services.

Responsibilities:

- Meet with individual clinicians for one-on-one supervision on a weekly basis.
- Provide impromptu supervision to clinicians in order to manage risk and client safety issues.
- Provide training/orientation for new clinicians.
- Monitor completion of client documentation and sign-off on comprehensive assessments and individualized action plans in the electronic health record.
- Review client documentation to insure that medical necessity is indicated.
- Participate in program development.
- Address clinicians' performance issues: develop performance improvement plans and manage HR issues as needed.
- Attend all required trainings.

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.
The noise level in the office / facility is usually quiet, but can be loud due to client participation in groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

Disclaimer:

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_____ _____

Signature Date

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **135 Direct Care/Program Staff II**

Position Title: Family Partner

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: MCI Program Manager

Education/Training:

- Bachelor's degree in human services field from an accredited university and one (1) year of experience working with the target population; **or**
- Associate's degree in a human service field from an accredited university and one (1) year of experience working with children/adolescents/transitional aged youth; **or**
- High school diploma or GED and a minimum of two (2) years working with children/adolescents/transitional aged youth.

Qualifications/Experience Requirements:

- Experience as a caregiver of a youth with serious emotional disturbance.
- Experience navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems.
- Willingness to provide mobile emergency services interventions/follow-up.

Responsibilities:

- Utilize personal and professional life experience to provide peer support to parents and caregivers served by the ESP.
- Learn the family's story, culture, strengths, and concerns.
- As requested, participate in Care Planning Team (CPT) meetings to ensure access, voice and choice within the wraparound process and to support the parent/caregiver's connection to the CPT members, as necessary.
- Serve as a bridge to ensure that family and providers understand each other's perspective and information.
- Provide a consistent source of encouragement and hope.
- Provide non-judgmental, unconditional support to parents and caregivers.
- Model effective coping techniques for parents and caregivers.
- Engage parent/caregiver in activities in the home and community.
- Assist the parent/caregiver with meeting the needs of the youth and meet one or more of the following purposes: Educating, supporting, coaching, modeling, and guiding.
- Promote parent/caregiver empowerment by including linkages to peer/parent support and self-help groups in the community.

- Teach the parent/caregiver how to identify formal and community-based resources (e.g., after-school programs, food assistance, housing resources, etc.)
- Meet weekly with an independently licensed clinician for supervision.
- Comply with all CCBC personnel policies and procedures related to employment.

List Other Job Requirements:

- Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.
- Maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren).
- Must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

Physical Requirements:

The ESP family partner provides home-based services and thus job responsibilities are often carried out in client's homes and in the community. All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **102 Program Director**

Position Title: Program Director

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: Vice President of Emergency and Diversionary Services

Summary of Position:

The Program Director (PD) is responsible for the overall operations of the ESP, including the supervision of all ESP staff and the clinical effectiveness of the program. The PD's primary function is to:

- Share responsibility with the ESP Medical Director for the clinical oversight and quality of care across ESP services.
- Responsible for the administrative and financial oversight of the ESP contract.
- Serve as primary point of accountability to MBHP and MCEs for the ESP.
- Ensure compliance with all requirements and performance specifications, including standard assessment tools, electronic encounter forms, and other data collection mechanisms.

Education/Training:

- Master's degree in Social Work or related mental health field or doctoral level.
- Must be independently licensed (LICSW, LMHC, PhD).
- Must have at least five (5) years post-graduate experience providing behavioral health services to children, families, and adults.
- Must have at least three (3) years of supervisory and/or management experience.

Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, potential safety issues, etc.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.

- Must be able to articulate and promote a recovery-orientation that is resolution-focused, strengths-based, and culturally competent.
- Ability to manage resources, including the hiring and retention of culturally competent staff.
- Possess knowledge and practice skills regarding Continuous Quality Improvement (CQI).
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties, as well as the written skills required to manage an electronic health record system.

Responsibilities:

- Administer the recruiting and hiring process for all ESP employees.
- Develop and maintain community connections with key stakeholders
- Develop and maintain programmatic policies and procedures to support a high fidelity ESP.
- Develop and maintain the training process and protocols for all new staff.
- Provide weekly individual and group supervision to staff and conduct regular performance reviews.
- Supervise program staff, which includes providing clinical support and oversight.
- Provide monthly trainings to all program staff to ensure compliance with all agency and managed care entities mandates.
- Oversee and ensure that all managed care entities' performance specifications and medical necessity criteria are being maintained by program.
- Collaborate with community resources, local and state agencies, schools, therapists and vocational programs.
- Facilitate monthly meetings and maintain collaborative partnerships with managed care entities and various states agencies including DMH, MCI and DCF.
- Provide oversight and support to all staff in ensuring they are completing all mandated responsibilities. This includes various quality management tasks and managing any staff disciplinary issues/performance improvement efforts.
- Manages various reports needed within the program to meet Mass Health requirements
- Provides on-going support to all team members as needed.
- Provides clinical oversight to all program matters and cases.
- Assist in the development of fiscal budgets and maintain program operations within allotted budget.

List Other Job Requirements:

All staff must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.

All staff must maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren). All staff must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

ESP RFR Attachment 3.5.3.7.2

Physical Requirements:

All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance. All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR):	**104 Supervising Professional**
Position Title:	Children's Outpatient Clinical Supervisor
Program Name:	Children's Outpatient Program
Service Type:	Outpatient
Accountability:	Reports directly to the Vice President of Children's Services

Education/Training:

- Master's degree in a human services related discipline.
- Licensed as an LICSW, LMFT, or LMHC by the Commonwealth of Massachusetts.

Experience Requirements:

Five or more years of experience (post-licensure) in a human service position. One – two years of supervisory experience. Must possess good organizational skills, effective written, verbal, and computer skills.

Summary of Position:

Provide clinical supervision to staff, and also provide clinical services to children, adolescents, and their families. Provide administrative support to the Vice President of Children's Outpatient Services.

Responsibilities:

- Meet with individual clinicians for one-on-one supervision on a weekly basis.
- Provide impromptu supervision to clinicians in order to manage risk and client safety issues.
- Provide training/orientation for new clinicians.
- Monitor completion of client documentation and sign-off on comprehensive assessments and individualized action plans in the electronic health record.
- Mandatory attendance at Supervisors' and Children's Team Meetings. Participate in facilitating these meetings.
- Attendance at the Monthly Management Meeting.
- Review client documentation to insure that medical necessity is indicated.
- Provide Emergency Responder coverage.
- Participate in program development.
- Provide outpatient therapy to a designated number of clients per week.
- Address clinicians' performance issues: develop performance improvement plans and manage HR issues as needed.
- Attend all required trainings.

ESP RFR Attachment 3.5.3.7.2

List Other Job Requirements:

Knowledge of Core-Competencies as identified by the employee's assigned department. Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

The noise level in the office / facility is usually quiet, but can be loud due to client participation in groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

Disclaimer:

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_____ _____

Signature Date

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **105 Physician (Psychiatrist)**

Position Title: Child Psychiatry Professional

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: ESP Medical Director

Education/Training:

- An MD or DO with Board certification in psychiatry or Board Eligible; or Advanced Practicing Nurse.

Experience Requirements:

- At least five years of experience in a community crisis intervention or behavioral healthcare setting.

Responsibilities:

- Provide clinical consultation to the ESP team in assessment and crisis interventions.
- Conduct psychiatric assessments and emergency consultations.
- Consultation to hospital medical/clinical staff as required.
- Provide after hours on-call consultation and support.
- Consultation to community providers as required.
- Educate consumers and their families regarding medications / symptoms / illness / side effects.
- Provide on-site crisis assessment and management and collaborate with acute and long-term inpatient providers.
- Collaborate with other service providers as necessary (i.e., inpatient psychiatrists, primary care physicians).

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

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Signature Date

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **123 Clinician (1.0 FTE)**

Position Title: Clinician / Mobile Crisis Intervention Specialist

Program Name: Mobile Crisis Intervention

Service Type: Mobile Crisis Intervention (MCI)

Accountability: MCI Clinical Supervisor

Education/Training:

- Master's degree in human services discipline.
- Licensed as a LMHC, LCSW, or LICSW in Massachusetts.

Qualifications/Experience Requirements:

- Ability to work a flexible schedule, including nights and weekends.
- At least one year of experience working with youth and their families in a clinical role within a mobile delivery system
- Knowledge of and experience with utilizing CBHI services and the Wraparound process.
- Able to provide clinical care and support to youth and their families to prevent hospitalization and stabilize youth in the community.
- Possess a valid driver's license and reliable transportation.
- Experience with computers, specifically Electronic Health Records (EHR) systems.

Responsibilities:

- Provide brief solution-focused interventions and reassess current level of need with youth waiting for higher level of care treatment.
- Post-crisis evaluation over the course of a seven day intervention period for youth deemed appropriate to return to the community.
- Provide brief solution-focused interventions.
- Work collaboratively with family partners to provide resources/referrals, support, and psychoeducation to families.
- Attend community-based meetings in conjunction with youth, their families, and providers to assist with advocacy and addressing safety concerns.
- Complete collateral contacts with a youth's providers.
- Assist with safety planning over the course of the seven day intervention period and outside the evaluation/intervention period
- Conduct comprehensive mental health status exam for youth and adults utilizing an admissions/screening instrument which includes providing a diagnosis in accordance with the DSM V and ICB-10.

- Understanding of different treatment modalities that can be applied to stabilize clients in their home and prevent hospitalization.
- Consult with clinic director/administrator on-call and or consulting psychiatrist prior to disposition plan to include outpatient services, hospitalization, or hospital diversion.
- Participate in regularly scheduled clinical supervision, staff meetings, staff development, and training curriculum.

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

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Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

D. 1.1 Proposed Program Budget

Appendix VIII ESP Cost Report

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 1 ORGANIZATION: Community Counseling of Bristol County, Inc. FY END: 6/30/2016 FEIN: 04-3035697

This schedule provides supplemental information for selected programs on an aggregated basis for use by the Commonwealth's Division of Health Care Finance and Policy in the establishment of so called "Class Rate" prices for certain Medicaid Eligible Mental Health Services. (Note that

1. UFR Program Numbers providing Mental Health Class Rate Services:

2. Program Staff and Expense Breakout by Service Component

Note: Schedule B positions not listed below are non-reimbursable for MH Class Rate services.	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE		ESP Management	
	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS
1S Program Director	1.00	62,202	0.00	0	0.00	0	0.00	0	0.00	0	1.00	62,202
2S Program Function Manager	1.00	62,202	0.00	0	0.00	0	0.00	0	1.00	62,202	0.00	0
4S Supervising Professional / QM / RM Director	0.40	22,828	0.00	0	0.00	0	0.00	0	0.00	0	0.40	22,828
4S Supervising Professional / Clinical Supervisor	1.10	62,273	0.40	22,645	0.00	0	0.70	39,628	0.00	0	0.00	0
5S Psychiatrist	0.80	177,360	0.30	66,510	0.30	66,510	0.00	0	0.20	44,340	0.00	0
7S N, Midwife, N.P., Psych N., R.N. MA	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
8S R.N. - Non Masters	1.00	62,751	0.00	0	1.00	62,751	0.00	0	0.00	0	0.00	0
9S L.P.N.	3.20	129,642	0.00	0	3.20	129,642	0.00	0	0.00	0	0.00	0
11S Occupational Therapist	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
21S Psychologist - Doctorate	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
22S Clinician-(formerly Psych.Masters)(UFR Title 12	9.70	523,164	3.00	161,803	1.50	80,902	3.50	188,770	1.70	91,688	0.00	0
23S Social Worker - L.I.C.S.W.	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
24S Social Worker - L.C.S.W., L.S.W	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
25S Licensed Counselor	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
26S Cert. Voc. Rehab. Counselor	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
28S Counselor	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ Cert Peer Spec.	1.00	44,380	1.00	44,380	0.00	0	0.00	0	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ BS and CPS	0.50	24,456	0.00	0	0.00	0	0.50	24,456	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ BS Milieu MHWI	4.20	126,616	0.00	0	4.20	126,616	0.00	0	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ Family Partner	1.70	75,446	0.00	0	0.00	0	0.00	0	1.70	75,446	0.00	0
33S Direct Care/Prog. Stf II/ Safety Staff	1.40	42,205	1.40	42,205	0.00	0	0.00	0	0.00	0	0.00	0
34S Direct Care / Prog. Staff I	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
35/36S Prog. Sec/Clerical/Maint./H-GmdsKeep.	1.30	43,550	0.50	16,750	0.30	10,050	0.00	0	0.00	0	0.50	16,750
38S Dir.Care O.T., Shift Differential & Relief	XXXXXX	0	XXXXXX		XXXXXX		XXXXXX		XXXXXX		XXXXXX	
39S **Total Direct Program Staff**	28.30	1,459,077	6.60	354,294	10.50	476,471	4.70	252,854	4.60	273,677	1.90	101,781
2E Chief Executive Officer	0.00	0										
3E Chief Financial Officer	0.00	0										
4E Acctng/Clerical/Support	0.00	0										
5E Admin Maint/House-Grndskeeping	0.00	0										
6E **Total Admin Employee FTE/Exp.**	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
7E Commercial Products & Svs/Mktng	0.00	0										
8E **Total FTE/Salary/Wages**	28.30	1,459,077	6.60	354,294	10.50	476,471	4.70	252,854	4.60	273,677	1.90	101,781
9E Payroll Taxes 150		145,908		35,429		47,647		25,285		27,368		10,178
10E Fringe Benefits 151		204,271		49,601		66,706		35,400		38,315		14,249
11E Accrual Adjustments		0										
12E **Total Employee Compensation & Rel. Exp.**		1,809,255		439,324		590,825		313,539		339,359		126,208
13E Facility and Prog. Equip.Expenses 390		75,000		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
14E Facility & Prog. Equip. Depreciation 301		4,100		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
15E Facility Operation/Maint./Furn.390		53,200		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
16E Facility General Liability Insurance 390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
17E **Total Occupancy - Allocated**		132,300		Expense		Dollars		Dollars		Dollars		Dollars
18E Direct Care Consultant 201		0										
19E Temporary Help 202		0										
20E Clients and Caregivers Reimb./Stipends 203		0										
21E Subcontracted Direct Care 206		0										
22E Staff Training 204		10,000		2,500		2,500		2,500		2,500		
23E Staff Mileage / Travel 205		15,000						7,250		7,250		500
24E Meals 207		34,800				34,800						
25E Client Transportation 208		2,000				2,000						
26E Vehicle Expenses 208		15,000				15,000						
27E Vehicle Depreciation 208		0										
28E Incidental Medical /Medicine/Pharmacy 209		5,000				5,000						
29E Client Personal Allowances 211		0										
30E Provision Material Goods/Svs./Benefits 212		0										
31E Direct Client Wages 214		0										
32E Other Commercial Prod. & Svs. 214		0										
33E Program Supplies & Materials 215		14,000		1,400		11,200		700		700		
34E Non Charitable Expenses		0										
35E Other Expense		0										
36E **Total Other Program Expense**		95,800		3,900		70,500		10,450		10,450		500
42E Other Professional Fees 410		0										
43E Leased Office/Program Office Equip.410,390		0										
44E Office Equipment Depreciation 410		0										
48E Program Support 216		21,280		2,240		17,920		1,120				
51E **Total Direct Administrative Expense**		21,280		2,240		17,920		1,120		0		0
52E Admin (M&G) Reporting Center Allocation		205,805		41,160		133,775		15,435		15,435		
53E **Total Reimbursable Expense**		2,264,440		486,624		813,020		340,544		365,244		126,708
54E Direct State/Federal Non-Reimbursable Exp.		0										
55E Allocation of State/Fed Non-Reimbursable Exp.		0										
56E **TOTAL EXPENSE**		2,264,440		486,624		813,020		340,544		365,244		126,708

Salary	CBL	CCS	A Mob	C Mob	ESP M
62,202.14					1.00
62,202.14				1.00	
57,071.04					0.40
56,612.00	0.4		0.7		
221,700	0.30	0.30		0.20	
0	0.00	0.00		0.00	
62,751.26		1.00			
40,513.20		3.20			
53,934.40	3.00	1.50	3.50	1.70	
44,380.18	1.00				
48,911.10			0.50		
[redacted]		4.20			
44,380.18				1.70	
30,146.74	1.40				
33,500.00	0.50	0.30			0.50

DMH Southeast Emergency Services Program Privatization Analysis

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 2

ORGANIZATION: Community Counseling of Bristol County, Inc. FY END: 6/20/2106 FEIN: 04-3035697

3. Service Statistics

Total Standard Unit Hours: 3,580

	CBL	CCS	ADULT MOBILE	CHILD MOBILE
Number of Weeks Service was in Operation (e.g., 52):	52	52	52	52
Defined Unit:				
Number of Defined Units Provided:	293	906	1,698	683
Average Number of Clients in Group:	N/A	N/A	N/A	
Average Number of Staff in Group:	N/A	N/A	N/A	

CBL Units are estimated at 30% of total Child ED and Mobile units.

4. Occupancy Space Utilization

TOTAL ESP				CBL		CCS		ADULT MOBILE		CHILD MOBILE	
Square Ft.Used	Occupancy Total Exp.	Square Ft.Used	Allocated Expense	Allocated Expense %	Allocated Expense Dollars	Allocated Expense %	Allocated Expense Dollars	Allocated Expense %	Allocated Expense Dollars	Allocated Expense %	Allocated Expense Dollars
2,400	132,300	2,400	132,300	0.38	50,274	0.58	76,734	0.02	2,646	0.02	2,646

5. SERVICE UTILIZATION AND REVENUE BY PAYER SOURCE

	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE			
	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS
Masshealth Only (non-MCE)	0.00	0										
Masshealth MCE MBHP	1,947.00	905,860	190.00	27,360	713.00	356,500	602.00	301,000	442.00	221,000		
Masshealth MCE Fallon	6.00	2,644	1.00	144	0.00	0	4.00	2,000	1.00	500		
Masshealth MCE NHP	454.00	211,336	44.00	6,336	27.00	13,500	280.00	140,000	103.00	51,500		
Masshealth MCE Tufts-Network Health	495.00	242,160	15.00	2,160	69.00	34,500	376.00	188,000	35.00	17,500		
Masshealth MCE BMC Health Net	516.00	246,608	32.00	4,608	69.00	34,500	341.00	170,500	74.00	37,000		
Masshealth MCE HNE	21.00	10,500	0.00	0	14.00	7,000	6.00	3,000	1.00	500		
DMH Only	0.00	0				0						
Medicare/Medicaid	0.00	0										
Medicare Only	0.00	0										
Uninsured	141.00	66,584	11.00	1,584	14.00	7,000	89.00	44,500	27.00	13,500		
Commonwealth Care Fallon	0.00	0										
Commonwealth Care NHP	0.00	0										
Commonwealth Care Tufts-Network Health	0.00	0										
Commonwealth Care BMC Health Net	0.00	0										
Commonwealth Care Celticare/Cenpatico	0.00	0										
Health Safety Net	0.00	0										
Care Plus BMC	0.00	0										
Care Plus Fallon	0.00	0										
Care Plus NHP	0.00	0										
Care Plus HNE	0.00	0										
Care Plus Celticare	0.00	0										
Care Plus Tufts-Network Health	0.00	0										
One Care CommCare Alliance	0.00	0										
One Care Fallon	0.00	0										
One Care Tufts-Network Health	0.00	0										
Commercial Insurer	0.00	0										
Commercial with MH TPL	0.00	0										
Other	0.00	0										
Total Service Utilization/Revenue	3,580.00	1,685,692	293.00	42,192	906.00	453,000	1,698.00	849,000	683.00	341,500	0.00	0

The above revenue and units are estimates given the data as presented was not sufficient to make a more accurate projection as rates are not available from most MCEs. Our projection of revenue assumes existing utilization and assumes that all interventions as noted in the Rolling Year Units April 14 to May 15 are reimbursable. For example not all CCS days may be authorized and therefore not all CCS days will be reimbursable. Also some Adult interventions may be ED follow-up of patients boarding in ED and therefore not reimbursable.

3.10 Privatization Law Assurances

Appendix X: Organizational Commitments Pursuant to Massachusetts Privatization Law

Under Massachusetts' Privatization Law (M.G.L. c. 7 §§ 52, 53, 54, and 55), a successful bidder must:

(i) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:

1. provided ESP services; and
2. were terminated as a result of DMH ceasing to provide such ESP services;

(ii) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees; the Commonwealth currently contributes 80% of the cost of health insurance DMH employees.

(iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate as determined by the state pursuant to M.G.L. c. 7 §54 (2) for those positions for which the duties are substantially similar to the duties performed by regular agency employees;

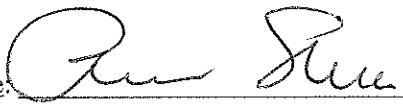
(iv) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons; and

(v) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

In addition, a successful bidder must certify in writing to the state that both the organization and its supervisory employees, while in the employ of the successful bidder, have "no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest."

Name of Organization: Community Counseling of Bristol County, Inc.

I hereby acknowledge that if the organization listed above is chosen to provide ESP services in the Southeast region of Massachusetts, the organization must implement the relevant provisions of the state's Privatization Law referenced above.

Signature: 

Name and Title (please type or print): Philip Shea, President/CEO

Date: 9/14/15

City of Brockton Massachusetts

Police Department
Office of the Chief

John W. Crowley, Chief 7 COMMERCIAL STREET, BROCKTON, MA 02302-2702 (508) 897-5350

September 8, 2015

Mr. Andrew Dawley
Community Counseling of Bristol County
1 Washington St.
Taunton, MA 02780

Dear Mr. Dawley;

The Brockton Police Department will support the efforts of your agency to work collaboratively if you are designated the Emergency Service Provider for the Brockton Area by the Department of Mental Health. We recognize and appreciate your work as a trainer for our police officers on the Community Crisis Intervention Team Model as well as your participation in our monthly Jail Diversion and Citizen X meetings in Brockton.

While we have already provided a letter of support for a competing agency, we will support the award decision by the Department of Mental Health. We wish you the best of luck in this competitive process.

Very truly yours,

JOHN W. CROWLEY
Chief of Police

/mnt

BAMSI
BRINGING PEOPLE & SERVICES TOGETHER

10 Christy's Drive, Brockton MA 02301
Telephone: 508-580-8700 • Fax: 508-580-3114
TTY: 508-580-0437 • Email: services@bamsi.org

Anthony Simonelli, Jr., Chief Executive Officer
Vanessa Tierney, Chief Operations Officer

August 26, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street
Boston, MA 02118

In Reply Refer To: #2015CEO-L24

To Whom It May Concern:

As you know, Brockton Area Multi-Services, Inc. (BAMSI) is a large behavioral health care provider based in Brockton that serves both children and adults. In that capacity, we have had occasion to collaborate with Community Counseling of Bristol County, Inc. (CCBC) in the delivery of care to our clients and have found them to be competent, professional, and responsive.

I understand that CCBC intends to submit a proposal to your organization to provide an Emergency Service Program for Brockton and surrounding communities. If selected, BAMSI would be pleased to work with CCBC in developing a more responsive and flexible Emergency Service program. Two of our programs in particular, Community Based Flexible Supports and Children's Behavioral Health Initiative, have frequent contact with Emergency Services given the population they serve. BAMSI would be eager to work with CCBC to develop an Emergency Service Program that could be responsive to our clients and produce excellent outcomes.

If you have any questions, please feel free to contact me.

Sincerely,

Anthony Simonelli
Chief Executive Officer

AS/msm

Massachusetts Behavioral Health Partnership (MBHP)
Emergency Services Program (ESP) RFR

APPENDIX VII: RESPONSE COVER SHEET

Organization name: Community Counseling of Bristol County, Inc.

Proposed catchment area name: *Please submit individual proposals pertaining to each catchment area for which your agency is submitting a response:*

☐ Brockton ☐ Cape and Islands ☐ Fall River ☒ Taunton/Attleboro

Contact person: Philip Shea **Title:** President/CEO

Mailing address: One Washington Street
Taunton, MA 02780

Telephone number: 508-977-8100 **Fax number:** 508-824-6604

E-mail address: Philip.shea@comcounseling.org

Proposed subcontractor(s), if any: *(Please repeat this section if proposing more than one.)*

Organization name: _____

Contact person: _____ **Title:** _____

Mailing address: _____

_____

_____

Telephone number: ___-___-_____ **Fax number:** ___-___-_____

E-mail address: _____

Service component(s) for which the bidder proposes to subcontract to the above:
___ Child Mobile Crisis Intervention
___ Adult Mobile Crisis Intervention
___ Community-based location
___ Adult Community Crisis Stabilization (CCS)
___ Other: (specify) _____

This cover sheet must be the first page of the bidder's response.

1. ***General qualifications and infrastructure: (30 points) – 5 PAGES***

1.1 Licensure:

1.1.1 Licensed as an outpatient mental health clinic by the Department of Public Health (DPH) ☒ Yes ☐ No

1.1.2 Licensed as a hospital

1.1.2.1 by the DPH ☐Yes ☒ No

1.1.2.2 by the Department of Mental Health (DMH) ☐ Yes ☒ No

1.2 Accreditation:

1.2.1 Accredited by a national organization ☐Yes ☒ No

1.2.2 If yes, please list accreditation(s). N/A

1.3 Currently contracted MassHealth provider or application in process: ☒ Yes ☐ No

1.4 At least three years' experience providing behavioral health services to a wide range of populations: ☒Yes ☐ No

1.4.1 Number of years providing behavioral health services to children, adolescents, and families: 45

1.4.1.1 Number of youth served in CY14: 3,000

1.4.2 Number of years providing behavioral health services to adults: 45

1.4.2.1 Number of adults served in CY14: 9,000

1.4.3 Briefly describe the behavioral health services your organization has provided and the populations to which your organization has provided these services.

Community Counseling of Bristol County (CCBC) is one of the largest community-based behavioral health providers in Southeastern Massachusetts and has been operating for over 45 years. CCBC has transformed itself from a traditional outpatient behavioral health provider delivering office-based treatment created from a medical-model to a strength-based recovery-oriented program with a broad continuum of services for children, their families, adults and elders.

Today CCBC serves over 12,000 clients each year, from children with serious emotional disturbance (S.E.D.) and their families, and adults with serious and persistent mental illness (SPMI), to frail elders. In addition to office-based treatment, clients also receive services in their homes, schools, health centers, and other community settings. CCBC has also become the leader in developing peer supports for adults and for parents with a child with serious emotional disturbance. We employ 14 peer specialists, most of whom are "certified peer specialists" (CPS) and 10 family partners. CCBC serves persons with serious and persistent mental illnesses in their outpatient clinics and under contract with the Department of Mental Health (DMH) for their Community-Based Flexible Supports (CBFS) and Program for Assertive Community Treatment (PACT) Programs. Both CBFS and PACT programs have developed strong collaborative relationships with local housing authorities and federal Department of Housing and Urban Development (HUD) to expand the supply of safe, stable, and affordable housing that is needed to support recovery. Additionally, the agency serves children with Serious Emotional Disturbance (SED) with a full continuum of services under the Children Behavioral Health Initiative and in our outpatient clinics.

Over the last twenty years CCBC has provided the 24-hour emergency psychiatric coverage to the Taunton/Attleboro Emergency Services Program (ESP) operated by the DMH. For the past twelve years CCBC has provided this psychiatric coverage to the Brockton Emergency Services Program. CCBC also leases space to house the operation of the Taunton/Attleboro ESP and

provides operational support for the Taunton/Attleboro Community Crisis Stabilization Program in Norton. Since 2013, CCBC has provided mobile crisis intervention services (MCI) to the DMH Emergency Services Programs (ESPs) in Brockton and Taunton.

1.5 Presence in and knowledge of the catchment area–for which your organization is applying for an ESP contract.

CCBC has operated programs serving residents of the Taunton/Attleboro catchment area for over 45 years through the operation of a full range of mental health, substance abuse, and related social service programs. These include three outpatient mental health clinics, two in Taunton, and one in Attleboro. CCBC operates two Community Based Flexible Support programs, one in Taunton for 154 clients, and another in Attleboro for 128 clients and a DMH-contract Program for Assertive Community Treatment (PACT) for 80 clients. CCBC is also the Community Service Agency (CSA) for the Taunton/Attleboro area, providing Intensive Care Coordination, Family Support, In-Home Therapy and Therapeutic Mentoring to children with SED and their families through the Wraparound model of care.

CCBC is also firmly engaged with the area's housing supports and resources that include the office of the Mayors of Taunton and Attleboro, the Taunton and Attleboro Housing Authorities, private landlords, homeless shelters, and other housing programs in the area, as CCBC coordinates the HUD Continuum of Care (CoC) for the Taunton/Attleboro area.

CCBC's Community Support Program (CSP) works with almost every type of social service provider to assist persons with serious mental illness (SMI) or addiction with basic needs, access to primary care, access to behavioral health care, and other natural community supports.

From their experience, CCBC has learned that there are many challenges in Taunton/Attleboro. The CCBC-contracted psychiatrists who have been part of the DMH ESP for 20 years have also developed a great deal of knowledge about the catchment area. Although not unique among cities in the Commonwealth, the cities of Taunton and Attleboro have been particularly hard hit by the increase in overdoses by those using opiates. Taunton in particular has had incidents of heroin overdoses well above the State average. Poor access to treatment for many seeking services due to excessively rigid admission authorization processes for 24-hour level of care complicates treatment. CCBC has taken an active role in the Mayor of Taunton's Opiate Task Force and is now working with the Taunton Chief of Police to create a response team for those individuals who have overdosed and their families who are seeking treatment.

1.5.1

1.5.1.1 CCBC's outpatient mental health program has been operating in Taunton/Attleboro for 45 years. CCBC's contract for Emergency Psychiatric Services for the Taunton/Attleboro ESP has been in place for 20 years. The Taunton/Attleboro PACT has been in place for twelve years and CBFS programs have been operating for six years. CCBC has operated outpatient mental health services in Taunton on a continuous basis for 35 years.

1.5.1.2 The CCBC PACT and CSP programs have been operating at One Washington Street, Taunton since 2005 in the Taunton/Attleboro catchment area.

1.5.1.3 CCBC plans to operate the ESP in the same location as the current Community Crisis Stabilization (CCS) program on 108 West Main Street in Norton.

1.5.2 The Taunton/Attleboro catchment area covers a broad geographic stretch from Lakeville in the southeastern section of the area down to North Attleboro in the northwest section of the area. The area has only two general hospitals, Sturdy Memorial in Attleboro and

Morton in Taunton, and two inpatient psychiatric hospitals, Arbour-Fuller in Attleboro and High Point in Middleboro. Taunton is a mid-sized city with a population of 55,000, with a diverse population that includes people from Portuguese, Irish, Cape Verdean, and Latino backgrounds. Beyond the 45 continuing care beds, the Taunton State Hospital campus houses a number of social service programs, including a DYS locked unit, a 45-bed psychiatric unit, and a Section 35 substance abuse treatment unit.

The crisis continuum in the Taunton/Attleboro area has several strengths: The hospital Emergency Departments located in the population centers, a Crisis Stabilization Program in Norton that is located midway between Taunton and Attleboro; Morton Hospital's new eight bed behavioral health unit in the ED; a range of CCBC-operated diversionary programs in the form of partial hospital and day treatment programs; and a Community-Based Acute Treatment (CBAT) program in Attleboro. The limitations of the crisis continuum include the capacity of the ESP staff to conduct mobile visits for both children and adults in psychiatric crisis beyond the two hospital emergency rooms at Morton and Sturdy. Another limitation is the absence of Acute Treatment Services (ATS) for those individuals needing a detox as a result of substance use and addiction in the Taunton/Attleboro area.

The difficulty in information exchange, while less visible, is also an obstacle to coordinated care and upstream preventive interventions. For example, the current ESP solicits crisis plans and safety plans from community providers, but does not have the capacity to integrate those plans into their electronic medical records system or retrieve them or other data from the EMR from remote locations. There are also delays in communicating information to ESP clinicians in the field about a client's prior history with the ESP. When community CBFS, CSP, and PACT providers develop a crisis plan for a client at risk, the paper document is rarely accessed by the ESP staff.

1.5.3 CCBC's wide range of community-based behavioral health and social service programs are firmly established throughout the catchment area, covering children's services provided by CCBC's CSA to adult services under CBFS, PACT, and CSP. CCBC's staff work in a myriad of community settings – with public housing authorities, in over 50 schools, the adult and juvenile courts, the newly established Manet Community Health Center, numerous home health agencies, private employers, 12-step programs, and the two hospitals. This reputation of established credibility will allow CCBC to quickly pivot those relationships into an effective and responsive ESP, especially with the local hospital EDs and community service programs that often refer persons for crisis intervention. CCBC's reputation is built upon staff commitment to resiliency and recovery for persons with mental illness, competency in accessing natural community supports to address the social determinants of health, and skill at engaging adults with SPMI, and children with SED and their families by drawing out their strengths to address these chronic but manageable illnesses.

Another strength is the CCBC psychiatry program currently contracted with the DMH ESP in Taunton/Attleboro. The CCBC-contracted psychiatrists will provide clinical continuity for that component of the ESP into the implementation of the CCBC ESP in Taunton/Attleboro.

The CCBC PACT and CBFS programs in Taunton/Attleboro are well-established with a host of community stakeholders in Taunton/Attleboro that include homeless shelters, local law enforcement, and local healthcare providers.

CCBC's reputation is one of cooperation, collaboration, community partnership, and accountability for these activities that promotes recovery, resiliency, and community-based care.

1.5.4 CCBC holds the contract with DMH for Emergency Psychiatric Services in the DMH ESP that is currently operating. The psychiatrists have a key role in diverting clients from inpatient care into the CCS program or back to their CBFS, PACT, or outpatient providers when the psychiatric emergency can be stabilized by ESP staff.

CCBC also holds a contract with DMH to provide Mobile Crisis Intervention (MCI) services that add capacity to the existing ESP. These staff are adept at working on a mobile basis throughout the Taunton/Attleboro catchment area, stabilizing family crises with a strength-based approach to the whole family and providing follow-up visits in the home to maintain the stability and extend community tenure during the course of a seven-day intervention and beyond, including timely referral to other CBHI services and other natural community supports. CCBC's CSA regularly interfaces with the current MCI program by hosting them at Systems of Care and Safety Planning meetings to develop a comprehensive safety plan that includes MCI for children at risk of acute episodes and their families.

The agency's Community Support Program (CSP) staff interface with a host of social service, behavioral health, and primary healthcare providers. They are very knowledgeable about the clinical baseline of persons with SPMI and skilled at working with these stakeholders, as well as landlords and law enforcement officials, to provide support that minimizes the current psychiatric episode, addresses the client's clinical triggers, and provides additional support to maintain the client's stability in the community and away from the ED and inpatient settings.

The CCBC Taunton/Attleboro PACT and CBFS program staff are well-trained to work with the 362 clients in a community setting to provide additional resources in a psychiatric crisis and minimize referrals to the hospital ED and ESP for evaluation.

CCBC is also the contractor in the Southeast area for the Runaway Assistance Program (RAP).

1.6 Continuum of care:

CCBC has evolved as an organization into a provider that has internalized a strength-based, recovery-oriented approach to the treatment of mental illness and addiction. CCBC management and clinical leadership have ensured that this approach is applied comprehensively and uniquely in each of the programs we operate: The Community Support Program has developed *"retail"* relationships with behavioral health and medical providers, including nurses in local emergency rooms. The ongoing collaboration has evolved into a credible relationship to make a case for diversions and community-based alternatives. CCBC's Community-Based Flexible Supports (CBFS) builds a full program around persons with SPMI that includes housing, daily supports, clinical treatment, and coordination with primary care providers to support recovery, manage co-morbid health conditions, and addresses any potential triggers to psychiatric crises that the clients identify. CCBC's Community Service Agency (CSA) has built a culture that is a family-focused and strength-based approach to strengthen the coping skills of families and their children to address crises in the home.

The psychiatrists assigned to the current DMH ESP contract have developed a body of experience to support increased diversion and client stabilization for community providers and ESP clinicians to address and stabilize psychiatric crises.

In the MCI program, CCBC has a group of clinicians already providing MCI services within the DMH program. CCBC will provide additional value for the Children's system in operating the MCI by bringing its skills and experience in collaboration to the Taunton/Attleboro Systems of Care meetings and actively participating with the other stakeholders to promote *"family voice*

and choice" and a strength-based approach to resolving psychiatric crises for children with SED and their families.

1.7 Administrative infrastructure:
President/CEO; Chief Operating Officer; Medical Director; Chief Financial Officer; Director of Children's Service; Community Service Agency Director; Quality Management Director; and Information Technology Support.

1.8 Medical and clinical infrastructure:
Chief Operating Officer; ESP Medical Director; Emergency Services Director; and Emergency Services Program Manager for Mobile Crisis Intervention.

1.9 Quality Management (QM) infrastructure

1.9.1 Key staff positions: Quality Management Director; and Utilization and Outcome Analyst

1.9.2 Required attachment: ***See Attachment 1.9.2***

1.9.3 Quality Management and Performance Outcomes: At CCBC, Quality Management is first and foremost defined by an organizational commitment to quality care and to a continuing process for improving that care. Supporting this commitment are organizational structures and processes designed to measure, monitor, and evaluate the care provided to clients in order to improve care. The components of this plan ensure the successful implementation of new services, such as the Taunton/Attleboro Emergency Services Program (ESP), as well as the ongoing operations of existing programs. Major components of this plan include:

- Risk Management Committee
- Utilization Management Plan
- Performance Improvement Committee
- Professional Services Review Committee
- Human Resources Management Committee
- Patient Care Assessment Committee

Upon a contract award, CCBC will develop a comprehensive evaluation plan for the Taunton/Attleboro ESP which will include:

- Development of specific tools to measure the Performance Indicators in the RFR.
- Establishment of specific performance targets utilizing a HIPAA compliant EMR.
- Establishment of a data set to submit to CCBC Executive Management on a monthly basis.

1.9.4 CCBC has established a series of "*Dashboard*" reports that will be adapted for the ESP in Taunton/Attleboro to measure volume of activity. These reports will be updated to stratify crisis interventions by location: Community-Based Mobile Crisis Intervention, such as school, home, or CBFS program site; ESP Community-Based Location, or Hospital ED. The volume will be tracked against the Performance Indicators in the RFR.

The Quality Management (QM) Director and staff will calculate compliance from the times marked on the ESP intake form with the 60-minute response time for face-to-face contact with the client requesting crisis intervention. Prior reviews of the data have led to improvements in staffing to reduce the response time.

The QM Director has access to a number of statistical programs to evaluate the data that is collected on outcomes, service delivery, and satisfaction. These include SPSS and SASS.

2. *ESP core competencies: (100 points) – 15 PAGES*

2.1 Crisis services

2.1.1 CCBC has provided the coverage for Emergency Psychiatric Services to the current DMH ESP programs in the Taunton/Attleboro catchment area since 1993 and in the Brockton catchment area since 2003. The psychiatrists are Board Certified in Psychiatry by the American Board of Psychiatry, and Neurology, have been credentialed and privileged by DMH and meet MBHP's credentialing criteria. In their role they have developed competencies in crisis assessment, risk management, safety planning, and in effecting timely placements for complex clinical presentations. The scope of duties includes medical oversight of clinical evaluations by ESP clinicians and clinical management of the Community Crisis Stabilizations (CCS) programs in the Brockton and Taunton/Attleboro catchment areas. Under this contract CCBC also leases the property in Norton where the Taunton/Attleboro CCS and ESP Community-Based Location are operated.

Since 2013 CCBC has also provided the DMH ESP's in Brockton and Taunton/Attleboro with Mobile Crisis Intervention (MCI) services on a contracted basis.

2.1.2 CCBC's psychiatric staff have responded to 24/7/365 requirements of the ESP for more than 20 years. The MCI contracted staff responds to requests for mobile visits within the 60-minute standard established for ESP programs. CCBC's In-Home Therapy staff has been trained to be flexible in addressing a family's changing needs, including increasing timely response when the family is in crisis or at risk. CCBC operates many programs that require and receive a rapid response on a 24-hour basis including: Community-Based Flexible Services (CBFS) Services; Program of Assertive Community Treatment (PACT); Community Support Program (CSP); Intensive Care Coordination (ICC); and In-Home Therapy (IHT).

2.1.2.1 Experience. The MCI staff under contract to DMH have been able to respond to requests for mobile visit within the required timeframe since the services were added to the contract. CCBC's clinical managers have provided clinical and administrative back-up for all of CCBC's adult and children's programs with established protocols and support for staff to meet client needs and contractor requirements.

Specific Strategies to Meet Response Time. First, CCBC will have a "*Central Telephone Triage Center*" to deploy clinicians from the Taunton/Attleboro ESP to meet the one-hour response time with back-up from relief staff in Taunton/Attleboro and relief staff in the proposed Brockton ESP. CCBC will use several additional strategies to meet the standard of a one-hour response time: 1) posting clinicians at Sturdy Memorial and Morton Hospital Emergency Departments during later afternoons and evenings, historically periods of high demand; 2) mobilizing additional mobile clinicians to provide back-up to these assigned clinicians when unusual demand spikes in the EDs; 3) expanding the pool of available back-up ESP staff in Taunton/Attleboro with on-call staff available from the Brockton ESP; and 4) through recruitment of additional on-call clinicians from CCBC's roster of licensed clinicians.

2.1.2.2 CCBC provides 24/7/365 psychiatric back-up with consistent 15 minute or less telephone responsiveness and meets all response requirements for MCI back-up to DMH. CCBC has a lengthy track record of managing these resources. The reports that CCBC submits to DMH indicate full compliance with the timeliness and other key contractual requirements.

Strategies. CCBC's Taunton/Attleboro ESP will strengthen the capacity to address the fluctuating demand by creating a position called "*hybrid*" clinician. This will be a CCBC salaried employee with access to full employee benefits. They will be hired at a reduced salary and

receive additional fees for providing mobile ESP crisis interventions across the Taunton/Attleboro catchment area.

CCBC will also develop a "*Central Triage*" to coordinate the efficient and timely use of clinical resources in the Taunton/Attleboro and Brockton catchment areas. Staff will be deployed in real time to where they are needed when fluctuations in demand require additional resources. An example of another strategy by CCBC to monitor timely access based on fluctuating demand will be the establishment of a "*Dashboard.*" The Dashboard will report data gathered from its ESP Electronic Health Record to review timely responses on a daily basis to ensure that all timeliness standards are being met. The Chief Operating Officer, Medical Director and ESP Program Director will meet weekly to review responsiveness, identify barriers to access, and implement corrective actions as needed in the Taunton/Attleboro catchment area.

2.1.2.3 Hiring Experience: Throughout the more than 20 years of the contract with DMH-operated ESP, CCBC has been successful in recruitment, hiring and retention of the psychiatrists for the Emergency Psychiatric Services contract in the DMH-operated ESP programs in Taunton/Attleboro and Brockton. CCBC has also had success in recruiting and retaining qualified staff for the MCI contracted program. CCBC's Human Resources Department recruits a range of staff for CCBC's other programs, many of which operate outside of the 9-5, Monday-Friday schedule.

Strategies to hire ESP Staff.

1. If awarded the contract, the executive staff at CCBC will outreach to the existing staff of the Taunton/Attleboro ESP to offer qualified staff positions in the CCBC program.
2. If awarded the contract, CCBC would recruit candidates for ESP, both internally posting ESP positions and externally through advertising and the engagement of a recruiting firm.
3. Through a contract with a national training organization, CCBC maintains a catalog of over six hundred online courses relevant to the needs of behavioral health care organizations. CCBC will add key training curricula on providing recovery-based crisis interventions for the ESP/MCI clinicians to be completed prior to their deployment.
4. Orientation and on-the-job mentoring to build skills in crisis intervention. As part of orientation to ESP, the new hires will shadow an experienced ESP clinician during the course of crisis intervention on eight separate cases. Before each new clinician is allowed to make independent clinical decisions, they must pass an ESP clinician "*Competency Test*" on ESP competencies.

2.2 Mobile services

2.2.1 CCBC has provided mobile services in Taunton/Attleboro through their CSP Program for 15 years and their PACT program for twelve years. The CSP serves over 500 clients per year in Taunton/Attleboro. These clients are MassHealth members at risk of psychiatric hospitalization or who typically have been recently discharged from 24-hour care. CSP case managers spend 90% of their working hours in community settings with these clients and work with them to prevent the need to utilize the ED and more restrictive 24-hour services. The CSP conducts these activities as mobile interventions throughout the Taunton/Attleboro catchment area.

The Taunton/Attleboro and Brockton PACT programs serve DMH clients with serious and persistent mental illness in community settings. The PACT program is a mobile team that sees the clients in many different community settings, essentially bringing clinical staff from peer

support to psychiatrist to the client. Based on DMH program evaluations, the CCBC PACT team meets the DMH standard of 90% client interactions occurring in a community setting.

The CCBC continuum of Children's Behavioral Health Initiative (CBHI services): Intensive Care Coordination, Family Support, In-Home Therapy, and Therapeutic Mentoring are all provided on a mobile basis to children with Serious Emotional Disturbance (SED) and their families. CCBC has been operating CBHI services for six years.

2.2.2 CCBC's orientation towards recovery in both adult and children's programs includes a foundation that most, if not all, services can be provided safely in the community. CCBC's wide variety of interventions – CSP, PACT, and MCI staff for the Taunton/Attleboro ESP – and CSP, CBFS, PACT, CBHI, and outpatient services in the Taunton/Attleboro area have resulted in a culture of community-based support for adults with SPMI and children with SED that promote client empowerment, a strength-based approach to the client and partnership in developing a wide range of solution-focused interventions.

Strategies. Based on this foundation CCBC will orient the ESP program staff to the effectiveness of mobile services in promoting recovery and resiliency. The ESP program director will gather examples of mobile interventions to demonstrate how mobile services can be effective as a crisis prevention and intervention tool. The menu of case examples will be expanded as the ESP staff build their own body of work through mobile outreach and intervention.

Another strategy to promote the value of mobile ESP services will be case presentations in community forums. The CCBC ESP staff will organize a monthly community meeting at which selected ESP mobile interventions will be presented to provide examples of how the ESP can provide an upstream intervention. In addition to CCBC's CBFS, PACT and CSP staff, the ESP will recruit the local behavioral health providers, members of the Taunton and Attleboro police force, representatives from the two hospital emergency departments, and Manet Community Health Center. The purpose of the meeting is to develop community-based preventive strategies to divert high-risk members from the Emergency Room.

As high volume referral sources are identified, the ESP program director will designate ESP staff as liaisons to these stakeholders, which may include group homes, nursing homes, or local police. These "*ambassadors*" will personally carry the message of the availability and effectiveness of mobile interventions in the community.

2.2.3 CCBC has conducted a preliminary assessment of the challenges in establishing a culture and practice of prioritizing mobile services listed below:

- The DMH-operated ESP does not prioritize mobile visits.
- Community stakeholders have limited experience with mobile ESP services.

Mobile ESP and MCI services can pose a risk of exposure to physical harm or crime in a few Taunton and Attleboro neighborhoods. To address and mitigate these challenges, CCBC proposes the following strategies:

- CCBC will improve the visibility of the Community-Based Location in Norton that is co-located with the Taunton/Attleboro CCS program.
- CCBC will develop a social marketing campaign to educate the stakeholders about the mobile capacity of the Taunton/Attleboro ESP.
- CCBC staff will establish orientation programs to the Taunton and Attleboro area neighborhoods and surrounding towns for ESP staff.

- ESP staff will conduct introductory meetings with homeless shelters, schools, and community health centers to build initial working relationships between ESP and sources of referrals for mobile visits.
- CCBC will also engage the members of the Taunton and Attleboro Police Departments who have participated in the Critical Crisis Intervention Team (CCIT) program to help as ambassadors to other law enforcement staff in the Taunton/Attleboro area in establishing a culture and practice for mobile services.

2.2.4 CCBC is the CSA provider in the Taunton/Attleboro area. We have established the full continuum of CBHI services and a number of working collaborations with community stakeholders, including the DMH MCI program. The hiring, orientation, and ongoing support for staff includes providing comprehensive training, supervision and ad hoc consultation for family partners and clinicians. CCBC has also developed a continuum of care with the DMH MCI program to support families in crisis during the seven-day crisis episode and also ensuring continuity of care with ICC and IHT services that will provide continued intervention for the family.

2.3 Diversion

2.3.1 ED diversion

2.3.1.1 CCBC's clinical leadership, which includes the medical director of the psychiatric services for the DMH-operated Taunton/Attleboro and Brockton ESP's, has a broad range of experience in assessing clinical risk for clients, both in the ESP setting and in our community programs that include PACT, CBFS, CBHI services, and CSP. Similarly the CCBC Child MCI Team that are part of the existing DMH ESP have two years of experience providing community-based diversion as an alternative to hospital level of care.

We have worked collaboratively with clients to develop individual safety plans that establish a clear set of supports for care that can be delivered in the community as an upstream intervention prior to going to the ED or inpatient hospitalization. These safety plans incorporate client strengths, preferences and natural supports that result in a consumer-directed plan. For families participating in the CBHI services, clinicians and family partners work with families and their children to develop a risk and safety plan to support families when the child is in a crisis, based on the child and family's strengths and preferences.

2.3.1.2 CCBC can expand on the existing relationships and add several important community resources to the Taunton/Attleboro catchment area to create and strengthen a culture of providing crisis services outside of the hospital ED. First, CCBC's ESP program staff will convene community stakeholders to reinforce their experience in working with high risk clients in community settings and emphasize the added value of the ESP to support these stakeholders. Second, the CCBC MCI staff will participate in the Taunton/Attleboro CSA System of Care meetings and share the capacity and competence of the MCI staff, as well as provide working examples of how children and families can be served in community settings by activating the Safety Plans. Finally, CCBC will build on the Community Crisis Intervention Training (CCIT) already provided to law enforcement and human service providers in Taunton to increase the visibility of the ESP and the CCIT skills to a larger law enforcement and human services audience.

The Taunton/Attleboro ESP will also develop the culture through rigorous data collection that aggregates the percentage of mobile visits versus ED visits and profiles ED visits that could have been seen in community settings. These data will provide concrete evidence to the

stakeholders – ED staff, parents, referral sources, and ESP staff – of the merits and effectiveness of ESP evaluations outside of the ED.

2.3.1.3 As part of the strategy to change the perception that all or most psychiatric crises must be sent to the local hospital ED, CCBC will familiarize key stakeholders with the value and utility of the Community Crisis Stabilization (CCS) programs, the Community-Based Location (CBL) in Norton, and mobile crisis intervention capacity for adults and children that can provide ongoing support for up to seven days as part of the Mobile Crisis Intervention (MCI). The targeted populations include clients served by the local offices of DMH and DCF, persons referred by local police, other mental health and substance abuse providers, and persons referred through local advocacy organizations such as PAL and NAMI-Mass, and consumer groups. Specific points to be emphasized in this targeted outreach will include:

- Increase awareness of the mobile capacity of the ESP;
- The capacity of the CCS to provide a staff secure setting that resembles an inpatient psychiatric unit in several ways;
- CCBC will change the perception of the law enforcement community by CCIT training with examples of law enforcement partnering with ESP providers to intervene effectively in community settings before transporting the member to the ED.

2.3.1.4 CCBC is aware of a number of challenges to the pattern of reliance on Hospital Emergency Departments for behavioral health emergencies:

- CCBC will have to forge expanded relationships with the two hospitals in the Taunton/Attleboro Areas: Sturdy Memorial and Morton Hospitals at the administrative, clinical and programmatic level.
- The recent of history of periods of high volume of mental health clients waiting in the Emergency Room for inpatient placement.
- The community stakeholders have only limited experience with mobile ESP visits from the DMH-operated teams.
- Mobile ESP and MCI services pose a risk of physical harm or criminal victimhood in some Taunton and Attleboro neighborhoods.

Strategies. With the social marketing campaign, CCBC will expand on the established relationships developed by the CCBC CBFS, PACT, and CSP programs with other community-based behavioral health providers and hospital systems, including their Emergency Departments. CCBC will have the relationships with other stakeholders through their participation in the Prevention and Wellness Network, Taunton Opiate Task Force, the Safe Neighborhood Initiative, the Greater Bristol County Attleboro/Taunton Coalition to end Homelessness, the Bristol County Regional Coalition for Suicide Prevention, and the Taunton Community Crisis Intervention Team and Case Conference Group, and the Attleboro CCIT Group. CCBC also has experience working with hospitals in preventing reliance on the ED for crisis interventions. Below are some specific steps that CCBC will take:

- CCBC's ESP medical director will reach out to the ED medical directors at Sturdy Memorial and Morton Hospitals to encourage their active participation in these forums to demonstrate the success of mobile visits and a willingness to set up a continuous quality improvement climate.

- The working relationship with the DMH Brockton area office and the staff who oversee the Taunton/Attleboro catchment area will provide a platform to work with the two hospitals and build trust and credibility.
- CCBC will eliminate the requirement for medical clearance for admission to the CCS.

CCBC will work with MBHP and local outpatient providers to improve access to Urgent Care appointments as a timely resource for persons evaluated by the ESP and needing immediate outpatient follow-up.

2.3.2 ED-specific plans

2.3.2.1 ***See Attachment 2.3.2 for specific plans for Sturdy and Morton ED's.***

Note: CCBC has recently begun outreach to the Sturdy Memorial and Morton Hospital EDs with a goal of establishing a Memorandum of Understanding (MOU) on a hospital-specific plan to work with the ED staff. The attached plans represent the first step in the completion of the MOU. Discussion with two EDs has led to ED requesting consultation for patients that are boarded temporarily in EDs awaiting inpatient admission. CCBC will offer psychiatric consultation to ED physicians to assist them in managing patients while they remain in the ED; a practice that does not happen with any frequency at present.

2.3.3 Diversion from unnecessary psychiatric hosp. and other out-of-home placement.

2.3.3.1 Taunton/Attleboro Diversion Experience. CCBC has an established track record of delivering community-based services such as PACT, CBFS, CSP and CBHI services that divert hospital admissions for both adult and child populations. CCBC also has experience at training community stakeholders, including law enforcement personnel, in preventing crises from escalating into higher risk situations that will precipitate a psychiatric hospitalization.

CCBC psychiatrists, including the CCBC Medical Director, Paul Weiss, M.D., also have experience working directly with ESP clinicians, hospital ED staff, and community stakeholders in managing psychiatric emergencies and diverting potential hospitalizations to the Community Crisis Stabilization program and other community-based alternatives. The seasoned staff that are part of the MCI contracted service for the Taunton/Attleboro ESP are also experienced at diverting hospitalizations. The new MCI program will work closely with the Taunton/Attleboro System of Care Committee that is organized by CCBC's CSA in the Taunton/Attleboro area to develop safety plans that are family-focused and strength-based, and designed to keep the child in his or her natural community setting.

2.3.3.2 Creating a Culture inside CCBC to accept community based alternatives. CCBC begins with a strong foundation of experience with the effectiveness of strategies to divert clients from inpatient hospitalization. In addition to the emergency psychiatry and MCI service, this experience derives from the operation of the Partial Hospital, Day Treatment, CSP, CBFS, PACT and CBHI programs. With the ESP program, CCBC will build on that foundation by providing concrete examples to the ESP staff of the client-centered, strength-based approach to clients in crisis in community settings that result in effective diversions. CCBC will also orient the ESP staff with presentations from peer specialists and family partners about effective diversions that underscore the recovery orientation of the CCBC programs, even for clients whose baseline symptoms may, at first, appear to meet hospital level of care, and can provide timely relief to the triggers that are individualized to the client's needs and preferences.

Creating a culture in the community and educating the community on alternatives. CCBC will build on the social marketing of the ESP features that include mobility to community settings, availability of peers, partnership with police, and 24/7 availability. The social marketing

campaign will be expanded to explain the clinical criteria for the Community Crisis Stabilization (CCS) program, the availability of the MCI to children and their families for up to seven days, and the commitment to member safety. The ESP will further build the culture by providing specific examples of diversion from hospitalization, involving both adults and children as the program gains experience in the Taunton/Attleboro catchment area.

CCBC will target its social marketing to the specific concerns of the coalitions on which they participate so that landlords, public housing managers, community health workers, law enforcement officials, primary care providers, and schools are fully aware of the capacity of the ESP to address psychiatric crises in a community setting.

2.3.3.3 Strategies for Diversion from Unnecessary Psychiatric Hospitalization.

1. CCBC will establish one new forum and strengthen two other existing forums to create a culture, educate others, and increase working collaboration on effective and timely use of community based alternatives. First they will establish a community meeting facilitated by the ESP to identify high-ED users, clients who are immediate risk, or clients who have a history of frequent non-compliance with community resources and often revert to the ED.
2. The second forum is the DMH Risk Meetings, which are convened to discuss crisis planning for PACT and CBFS clients in the Taunton/Attleboro area. CCBC will set up the electronic health records to have the capacity to share information on ESP evaluations with the community providers and, conversely, for the community providers to submit their crisis plans to the ESP, so that the plans can be activated if the client presents for an ESP evaluation.
3. Third, CCBC will participate with DMH in their meetings with the local homeless shelter, Samaritan House, to identify potential community interventions for homeless clients at risk of acute psychiatric episodes.
4. CCBC ESP will expand the working relationship between CCBC psychiatrists and ED physicians to be available to consult with ED physicians at Sturdy Memorial and Morton Hospitals to offer consultation, including recommendations for medication management while the individual is in the ED.
5. CCBC will become an advocate for the use of alternatives to inpatient hospitalization to the treatment community. The CBFS, CSP, PACT and Partial Hospital programs are examples of the creative use of diversionary services in Taunton/Attleboro that promote recovery and individual client choice. CCBC will conduct follow-up meetings with referral sources to debrief on dispositions where the referral source disagreed with the outcome.
6. CCBC ESP will also act proactively with the higher volume referral sources identified by the encounter forms, such as schools, law enforcement, and homeless shelters. CCBC will meet with them regularly to clarify hospital level of care and the many viable alternatives offered by CCBC and other community providers. CCBC will seek to expand the CCIT program for Law Enforcement personnel in Taunton. This program trains law enforcement in de-escalation techniques for person in crisis. The ESP will be available for more face-face collaboration with police in the Taunton/Attleboro area.

2.3.3.4 CCBC does not expect to establish a "designated ED" model in the Taunton/Attleboro catchment area.

2.4 Recovery-oriented Services

2.4.1 Hiring Practices

2.4.1.1. For the past twelve years CCBC has employed staff, including peer specialists, in many of its adult programs and for the past six years in CBHI Programs that have

included family partners: PACT, Day Treatment, Partial Hospital, CBFS, and Elder Mobile Outreach Team. CCBC current includes 14 peer specialists in its program serving adults. All of CCBC's peer specialists are either certified though the Transformation Center or in the process of becoming certified. Program staff are hired based on their orientation to the recovery models in PACT, CBFS, Outpatient, and CBHI models of care that include a combination of the medical model and the recovery model.

CCBC is also the Community Service Agency (CSA) for the Taunton/Attleboro catchment area. All CSA staff are trained in the Wraparound model of recovery that focuses on "*family voice and choice*" and a strength-based approach to children with serious emotional disturbance (SED) and their families. CCBC employs 10 family partners.

2.4.1.2 CCBC has recruited Family Partners from families who have received services from the CSA. Other recruitment strategies include: reaching out to graduates from the Recovery Learning Community, persons in recovery who serve on CCBC advisory committees and task forces. CCBC has recruited family partners for the MCI Relief program. Through the many linkages to other social service providers in the Taunton, Attleboro, Brockton and surrounding Bristol County, CCBC has established credibility to recruit all types of staff through word of mouth and networking.

2.4.2 Integration of Peers and Family Members

2.4.2.1 There are two members of CCBC's Board of Directors who are in recovery and one of them is the parent of a child with SED. Several enrollees in CCBC's PACT and CBFS programs also serve on CCBC's Human Rights Committee.

2.4.2.2 CCBC employs 14 peer specialists in that program and in its adult programs. Ten family members with lived experience involving a child with SED are employed as family partners in the Community Service Agency. One senior family partner is also a member of the MCI contracted staff in the current contract with the DMH-operated ESP program in Brockton. CCBC intends to hire both peers and family partners as part of the ESP program staffing model. In addition, CCBC would include recovery-oriented training for all staff. This would include contracting for training with the Transformation Center and others recognized for their articulate voices on the subject of recovery from the perspective of someone with lived experience. North Suffolk Mental Health Association's Director of Recovery would provide this training.

Peers participate in a long standing local cable television program, "The Other Side," focusing on recovery and featuring local community resources and CCBC clients in recovery. CCBC has produced over 100 shows to date. Peer specialists will be deployed to run groups in the CCS and provide support to clients and families in the Community-Based Location of the ESP.

2.4.2.2.1 CCBC's ESP program will have the benefit of the successful recruitment activities of CCBC's Human Resource Department to recruit, hire and train peers and family partners for the ESP. These strategies include outreach to the regional Recovery Learning Center, to parents who have completed involvement with the CSA program, word of mouth at local task forces and advisory groups that CCBC participates in, as well as traditional advertising in local and regional newspapers.

Both peer specialists and family partners who work in the ESP will have access to peer supervision as established in the CSA and CBFS programs: a senior family partner and a senior peer specialist will provide weekly supervision as well as ad hoc supervision as needed. Peer specialists and family partners will meet regularly with peer specialists and family partners in other programs to facilitate their learning and provide support.

2.4.3 Adherence to recovery principles

2.4.3.1 ***See Attachment 2.4.3.1***

2.4.3.2 CCBC's existing CBFS, PACT, Day Treatment, Partial Hospital, and CBHI programs all practice the principles of recovery as described in Section II.B, including the reference to SAMHSA and Section II.C. The elements of a strength-based approach that empowers the individual to develop a holistic plan are contained in the team-based approach with members' active participation in each of these four programs. The practice of including peer supports on the treatment team and working with the client are wholly integrated in the Wraparound Planning process and in the PACT, Day Treatment and CBFS programs. The approach to clients is individualized and holistic because clients are encouraged to identify their own preferences, supports and solutions to ongoing treatment *as well as* to help them respond to any triggers that may put the client at risk of harm to self or others. These supports include friends, neighbors, other peers, and 12-step programs, including the Dual Recovery Anonymous program that started in Massachusetts by CCBC.

CCBC is experienced in respecting clients' preferences; staff are trained to be open to many different pathways to recovery that include natural community supports, and are accepting of the non-linear nature of recovery from mental illness, substance use disorders and serious emotional disturbance in children and adolescents.

These principles and practices will be integrated seamlessly into the ESP program through training and orientation of ESP clinicians, the presence of peer specialists and family partners and sharing with the ESP the successful examples from CCBC's current practices. In sharing these successes with ESP staff, the community-based interventions centered on client preferences will become a model for ESP staff to establish creative interventions that address clients with escalating symptoms in a community setting, deploying a full range of safe and effective holistic interventions. The peer specialists and family partners are active members of the treatment teams.

Another practice of these programs that is critical to the successful implementation of the recovery principles is the recognition that recovery is individualized and non-linear. The ESP will have staff – clinicians, peer specialists and family partners – that can be flexibly deployed to address members' individualized needs during the course of a crisis episode. CCBC recognizes that effective engagement is best accomplished by understanding the stages of change as outlined in the techniques of Motivational Interviewing. The community orientation of the ESP will encourage engagement with the client in a setting that is comfortable and safe for the client and this will provide the best opportunity to engage the client and partner with them in addressing the psychiatric crisis.

2.4.3.3 CCBC recognizes that clients in psychiatric crisis present challenges to the recovery orientation in which dangerousness to self and others must be balanced with client choice and a strength-based approach. CCBC will address this challenge by training all ESP staff, including family members and peer specialists, in the essential elements of client safety and dangerousness that relate to acute phases of mental illness and co-occurring mental health and substance use disorders. Within this frame, client choice and strength can still be activated and incorporated into the treatment plan once the acute phase of the illness has been stabilized. The ESP will make a clear delineation to the clients at the outset of their right to refuse care to promote client empowerment, but also be clear on the staff's obligation to make a judgment about client safety and risk of harm to others that will be balanced in the clinical disposition. CCBC has found that the clear delineation of these practices at the outset of the intervention assists in partnering with the clients.

ESP clinicians will also have access to timely clinical supervision and consultation with the ESP clinical supervisor, the ESP program director, and the ESP psychiatrists to address safety concerns and the soundness of diversion plans.

2.5 Culturally Competent Services

2.5.1 Population and related experience

2.5.1.1 By virtue of providing PACT, CSP and MCI services in Taunton/ Attleboro and the surrounding communities, CCBC is very familiar with the racial, cultural and linguistic composition of the area and the importance of delivering culturally effective services to its clients. The cities and towns in the Taunton/Attleboro catchment area includes: Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleboro, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, and Taunton. The current racial, ethnic, cultural, and linguistic composition of the population in the Taunton/Attleboro catchment area includes the following pertinent data:

The population of the City of Taunton as of 7/2013 was 55,069. The racial make-up of the city of Taunton includes 84% White, 5% African American, and Hispanic/Latino of any race is 6.73%. Taunton has a large mix of ethnicities represented in the city, including 23% Portuguese 17% Irish, 9% English, 9% French, 8% Cape Verdean and 4% Puerto Rican. 19.2% of its citizens speak a language other than English in the home.

The racial makeup of the city of Attleboro includes 87.1% White, 3.0% African American, and 6.3% Hispanic/Latino. The remaining communities have a much higher percentage of individuals with a Caucasian background. Attleboro also has a small but significant population of émigrés from Cambodia and their American born children.

2.5.1.2 CCBC's current programs serve a diverse population linguistically and culturally: Latino, Hispanic, Portuguese, and Haitian cultures are represented in our client base, as are a number of languages in addition to English, including primarily Spanish, Portuguese, French, and Creole. CCBC strives to incorporate the Department of Public Health's Cultural Linguisitc Appropriate Services (CLAS) standards and guidelines with respect to trainings, staffing, brochures and staff languages, and to ensure that design, delivery, and monitoring of all services consider issues of race, ethnicity, culture, language, sexual orientation and gender.

The agency has a wealth of experience serving individuals from a variety of cultural and ethnic backgrounds. CCBC's local area includes a significant population of Portuguese and Spanish speaking residents. At present, CCBC employs 27 staff who are bi/multi-lingual and available to do interpretation in languages that include Portuguese, Spanish, French, German, Danish, Somali, Arabic, Italian, Creole, and American Sign Language (ASL).

2.5.1.3 CCBC operates many services that are tailored both culturally and linguistically to meet the needs of the clients served as reflected in the staffing in its CBFS, Community Support Program and Program of Assertive Community Treatment in Taunton/Attleboro. CCBC's CSP, which is made up of case management staff providing services to all of the communities this proposed program will serve, has the ability to work with clients speaking Portuguese, Spanish, and French Creole.

2.5.1.4 CCBC has been aware of the need to outreach the Asian community in all of our catchment areas as well as the French Creole population in Taunton. An effort to hire staff with cultural and ethnic backgrounds in this area and the ability to train other staff to understand the specific needs of these groups will be important to address any emergency services or crises that may arise. CCBC will also make a concerted effort to engage leaders and

resources in those communities to promote the availability of emergency services as well as other behavioral health services.

2.5.2 Organizational Capacity

2.5.2.1

2.5.2.1.1 The composition of the CCBC Board of Directors is currently made up of men and women who are Caucasian, with varying cultural backgrounds and linguistic capabilities as well as those in recovery who bring critical perspectives to the agency. The Senior Management includes a team of Vice Presidents, Program Managers, Team Leaders, as well as a Clinical Team that includes individuals in positions of critical importance to the agency who are Caucasian, African American, Cape Verdean, and African. It is CCBC's plan to increase the number of Board Members, senior managers, as well as others in critical positions, particularly in the ESP programs who will represent the racial and ethnic population.

2.5.2.1.2 CCBC's Board of Directors (BOD) has taken on the initiative to develop Advisory Boards for the agency to meet the needs of specific programs. One example of this includes The Consumer Advisory Board (CAB) which serves the Greater Taunton Area's HIV Positive Community. It monitors services provided and reviews programs to ensure they are living up to what they are contracted to do. The CAB seeks to have as diverse a membership as possible so that the perspective of all People Living With HIV/AIDS (PLWHA) in the Greater Taunton Area is represented. Currently one CAB member is hearing impaired, one is Hispanic, and one is African American.

2.5.2.1.3 CCBC seeks to ensure that staff members reflect the cultural and linguistic characteristics of the population served, and as such we are committed to providing services that acknowledge and enhance the dignity of all, with a particular recognition and focus on the MassHealth-enrolled population. CCBC currently has 27 staff who are bi/multi-lingual and available as interpreters. Languages spoken include Portuguese, Spanish, French, Somali, Arabic, Italian, French, Haitian and CapeVerdian Creole, Romanian, and American Sign Language.

2.5.2.1.4 CCBC uses its internal capacity for interpreters first as described above in 2.5.2.1.3, and if necessary employs the local interpreter services available through a service we have contracted with "Optimal Phone Interpreters" who provide instant interpretation in any language. The process is as follows: 1) *Call OPI*: Call 1-877-Ring-OPI (1-877-746-4674) 2) *Connect*: OPI asks what language and confirms your location 3) *Interpret*: Speak directly with an OPI interpreter. OPI also offers CCBC video remote interpretation for communicating with the deaf and CCBC also offers sign language interpreters through the Massachusetts Commission for the Deaf and Hard-of-Hearing, Deaf Inc. and other local providers who are available by developing a memorandum of understanding. At time of hire, all CCBC staff is asked to complete a form that lets HR know what language capability they have and their willingness to be involved in interpreter services for other agency programs in addition to the program they are working in.

2.5.2.1.5 ***See Attachment 2.5.2.1.5***

2.5.2.2 CCBC's mission statement clearly addresses the need for culturally competent services as a priority for the agency:

To develop and deliver compassionate, responsive, culturally competent, and quality mental health and substance abuse services to meet the prevention, education, treatment, rehabilitation and recovery needs of those in our community. These services are based on the latest evidence-based approaches to respond to the complex needs of children,

adolescents, adults, elders and families as part of a locally integrated health-care delivery system linked to regional and statewide delivery systems.

CCBC has recently completed a total revision of our policy and procedure and our employee manuals, both including a focus on cultural competency and the need to include definitions, values, and respect for the various cultures we serve as well as the staff that work for the agency.

2.5.2.3 CCBC has developed training for all staff that will increase awareness, understanding and cultural sensitivity of the diverse populations in the communities that CCBC serves. All of the strategies to ensure cultural and linguistic competency at CCBC are based on the following definition adopted by CCBC: ***The knowledge and interpersonal skills that allow individuals to understand, appreciate, communicate with, and work with, people from cultures other than their own.***

CCBC also incorporates the following expectations into our agency and staff practices regarding cultural competence:

- Cultural Awareness: Every culture holds distinct biases, values, beliefs, practices, lifestyles and problem-solving techniques which can affect clients' use of health services.
- Cultural Self-Awareness: Staff has awareness of our own biases, values, beliefs, practices, lifestyles and problem-solving techniques that may affect interactions with those they work with, from their own or other cultural groups.
- Cultural Respect: Treat all clients with dignity, consideration for, and understanding of the value they place on their beliefs.
- Cultural Knowledge: Staff have 1) in-depth knowledge of one or more cultures, including concepts of illness, family context, and other factors impacting health and health behavior; 2) knowledge of illnesses and conditions more common among individuals of particular races and ethnic groups.
- Cultural Assessment: Staff assesses the extent to which clients' beliefs are aligned with those typically associated with his/ her culture of origin.
- Cultural Adaptation: Staff reasonably adapts their approach to clients' cultural values, beliefs, practices, lifestyles and problem-solving techniques.

2.5.3 CCBC will build upon its strong working relationships with the local provider community, and with the larger network of supports and services in the Taunton/Attleboro catchment area, to help meet the needs of those needing emergency services. CCBC has developed extensive partnerships with minority, community-based organizations, mutual assistance agencies, and other multi-service agencies for immigrants and refugees to meet the care and support needs of our clients. This includes our extensive experience working in concert with the Literacy Center in Attleboro as well as Catholic Social Services, who both provide specialized services to immigrant populations. Both organizations have worked closely with our Supportive Housing, CSP, and PACT programs serving the Taunton/Attleboro area. In the case of our collaboration with the Literacy Center, we were able to work together to address the cultural and linguistic barriers to the effective treatment of an Iraqi immigrant who was suffering from both acute medical as well as psychiatric illnesses. CCBC also has worked collaboratively with the local Portuguese civic organizations to promote cultural and social initiatives and events.

2.6 Other special populations

2.6.1 Elders – CCBC operates the "Elder Mobile Outreach Team" (EMOT) which provides urgent care to elders with behavioral health care needs.

2.6.2 Veterans – CCBC serves Veterans who are homeless through CCBC's Community Support and Housing Partnership programs. CCBC's ESP will have access to case consultation to this program when a Veteran presents in psychiatric crisis.

2.6.3 Persons who are homeless – CCBC has developed a successful housing partnership in Taunton with property owners, city housing authority officials, DMH, and homeless shelters to provide clinical, social and housing supports to clients at risk for chronic homelessness. CCBC recently received a three year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the support need of chronically homeless veterans and others in the community who have a substance use disorder.

2.6.4 Persons with substance use conditions – CCBC's outpatient clinics are licensed by BSAS as substance abuse clinics with accompanying expertise in treating substance use disorders. The orientation for ESP clinicians will include training in substance use disorders including screening and motivational interviewing.

2.6.5 Persons with co-occurring mental health and substance use conditions – Between 50 and 75% of ESP clients in any given month present with a co-occurring disorder. CCBC's clinical staff have established clinical protocols in the assessment, diagnosis and treatment for persons with co-occurring conditions that addresses the functional barriers the client is facing.

2.6.6 Persons who are deaf and hard of hearing – CCBC will receive training on work with persons who are deaf and hard of hearing from North Suffolk Mental Health Association who has a specialized CBFS and community support program for this population. CCBC also has staff with competence in American Sign Language.

2.6.7 Persons who are blind, deaf-blind, and visually impaired –
CCBC utilizes the local consultation services of Mobility and Orientation Specialist Donna DiCorpo, M.Ed. as needed.

2.6.8 Persons who are involved with the Department of Mental Health (DMH) – As the CBFS provider, CCBC is the leading provider of services to persons who are involved with the MA Department of Mental Health in the Taunton/Attleboro area. CCBC operates outpatient clinics in Taunton, and Attleboro and CBFS and PACT teams in the Taunton/Attleboro area. CCBC has well-established protocols for this population that include access to ESP's and ESP interventions in community-based settings as part of the member's Wellness Recovery Action Plan and the member's Safety Plan.

2.6.9 Youth and families involved with the Department of Children and Families (DCF) – About 50% of children presenting to the ESP are involved with DCF. CCBC works with the DCF Area Office in an Advisory Capacity. The CCBC CSA engages DCF to participate in the Taunton/Attleboro System of Care meetings that include the role of MCI as a part of the intervention and safety plan for the child and family.

2.6.10 Youth and families involved with the Department of Youth Services (DYS) and/or the juvenile court system – CCBC is the designated CSA for the Bristol County Juvenile Diversion Project that involves the Bristol County Juvenile Court, Probation Officers, the Court Clinic, and other Law enforcement officials.

2.6.11 Youth who are on the Autism Spectrum – Paul Donnelly, Ed.D., a consulting psychologist to CCBC, is experienced with this population. He will provide consultation and

training to the ESP staff on working with this population when they appear in crisis and with escalated behavioral presentations.

2.6.12 Persons who are receiving services from Dept. of Dev. Disabilities (DDS) – Paul Donnelly, Ed.D., a consulting psychologist to CCBC, with considerable experience with those with developmental disabilities, will provide consultation and training to the ESP staff on working with this population when they appear in crisis and with escalated behavioral presentations that can often be managed more successfully in settings outside of an ED and an inpatient hospital.

2.7 Intersystem planning and affiliation

2.7.1 CCBC is well known in the Taunton/Attleboro area and throughout Bristol County for its organizational commitment to collaborating with other providers, payers, advocates, and clients to create integrated systems of care. CCBC has taken leadership in a number of community projects and CCBC is the conveyor of projects such as:

- The Continuum of Care for Greater Bristol County Attleboro/Taunton Attleboro Coalition to End Homelessness which includes the Mayors of Taunton and Attleboro, local housing authorities, Department of Mental Health, and human service providers and local businesses. CCBC manages $1 million in HUD funding annually on behalf of the Coalition.
- The System of Care meetings convened by the CCBC CSA involve all local stakeholders involved with youth: DCF, DYS, local schools, day care providers, juvenile court, and after school programs.
- CCBC chairs the Taunton HIV Consumer Advisory Board (CAB) to reduce stigma and ensure access to services for persons with HIV/AIDS.
- The Mayor's Opiate Task Force in Taunton is co-chaired by a CCBC senior manager, along with the city's director of human services.
- CCBC convened a local Committee to gather support for a SAMHSA grant to service homeless veterans. A three year contract has recently been awarded to CCBC and this group will serve as the grants Steering Committee and includes: DMH, BSAS, MBHP and others.
- CCBC convened a local coalition group of healthcare, behavioral healthcare and public health professionals to develop a proposal to the Health and Wellness Trust Fund of DPH.

2.7.2 CCBC will expand the culture of collaboration in the Taunton/Attleboro area with the implementation of the ESP. In order to respond on a timely basis to referrals for ESP intervention and in order to meet the goals of reduced reliance on the Emergency Departments of local hospitals, increased mobile crisis interventions and reduced reliance on inpatient hospitalization, CCBC will work closely with the key stakeholders and build new relationships to actively work towards these goals.

As a new ESP provider working with a very visible and high need population, CCBC will build credibility by engaging with the stakeholders with several principles to guide the collaboration:

- A data-driven approach is the best method to solve problems;
- Each stakeholder deserves a timely, polite, response that emphasizes the value of fully understanding the issue of the person(s) working with the ESP;
- Solutions are best developed in collaboration;
- In psychiatric crisis, there will always be unusual clinical presentations that are best solved in a calm, accepting and collaborative atmosphere.

First, CCBC will establish a working group to help CCBC ESP Program managers and staff implement the new program and provide a forum to review progress and address key issues in

the operation of the ESP. The working group will be co-led by the ESP program director and the ESP psychiatrist. It will consist of representatives from all of the important stakeholders.

Second, CCBC will distribute information using multiple media about the operation of the ESP, that highlights 24/7 phone availability, access to the community-based location, mobile capacity, and the seven-day model of MCI intervention.

Third, ESP clinical and programmatic leaders will reach out to their counterparts to introduce themselves in person, by phone, by email and by social media to an expanded list of community stakeholders. From the information gathered, CCBC will develop measurement tools that will provide a data-driven approach that will allow CCBC to be responsive to the priorities reported to them.

Fourth, CCBC will establish a subcommittee of the working group to form a Critical Risk Teams to include peer specialists and family partners. The teams will develop safety plans that include the client's preferences and the strengths that the client identifies that will help him/her and their family maximize their safety through the use of less restrictive alternatives. This group will be chaired by the clinical director of the ESP.

Finally, CCBC will undertake a Performance Improvement (PI) initiative to survey persons who come directly to the hospital ED's to determine their knowledge of the ESP, the pathway that resulted in directly coming to the ED, and their willingness, and the willingness of the referral source, to consider alternatives in similar circumstances. This PI effort will help CCBC and the community stakeholders identify the **root causes** of reliance on the ED so that the ESP can target corrective actions in the most effective direction.

2.8 Staff training, monitoring, and evaluation. CCBC will enhance our current training, development and evaluation of staff to include the goals of timeliness of response, diversion from the ED, increased mobile visits and reduced reliance on inpatient hospitalization.

All CCBC staff positions have a set of core competencies that are established for the position. A set of required internet-based and in house video trainings and live training sessions are established to align with the core competencies. Staff complete the required trainings each of which includes a test that must be passed before credit for the course is given. Training also includes shadowing seasoned ESP clinicians. Once the clinician is conducting assessments independently, the clinician has to review the findings and recommendations with the CCBC Administrator on Call (AOC) in order to complete the intervention. Before the clinician attains complete autonomy, s/he must pass the ESP clinician "*Competency Test.*"

Competency will be maintained through monthly staff meetings, weekly supervision for clinicians seeking licensure, and case-by-case supervision for all staff when needed. The AOC is available for case consultation at any time.

CCBC will also work with staff to improve the overall performance of the program through a number of Program Evaluation Indicators. One is the Consumer Satisfaction survey which is aggregated twice a year by CCBC's Quality Management Coordinator. Previous outpatient surveys have resulted in a Performance Improvement effort to address waiting time. The corrective action was the development of a Rapid Access Project that provides same day access to outpatient services.

The CCBC QM staff will also measure the performance of the ESP on key indicators related to the timeliness of telephone and face-to-face response, the percentage of mobile visits for children and adults, the percentage of community-based and ED face-to-face contacts, and the use of alternatives to inpatient hospitalization.

3. ESP service components: (100 points)

3.1 Emergency Services Program (ESP): overall program

3.1.1 Provide a brief program description that summarizes your overall ESP program model addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

3.1.1 Since its inception as an organization Community Counseling of Bristol County, Inc. (CCBC) has tirelessly pursued the development of a comprehensive, recovery focused integrated system of behavioral health in Bristol County and the Southeastern region of Massachusetts. We take pride in providing a broad array of innovative services to children, adults and elders struggling with mental health and substance use disorders so that they and their families may live full and functional lives in their communities. CCBC views the Emergency Services Program (ESP) as a critical, distinct level of care in the behavioral health delivery system, sitting at the nexus of acute and sub-acute services for adults, children and adolescents.

In our experience, early and effective intervention is invaluable as a means of promoting resiliency and recovery, while also preventing potential crises from becoming more protracted, painful and costly episodes of care. Central to this effort is a team of capable clinicians, peer specialists, family partners and consulting psychiatrists who are experienced at engaging the client and family rapidly and respectfully. Our experience has demonstrated that the fullest participation of the client in the process leads to the best treatment outcomes. Our role is to respect the client's preferences in arriving at an appropriate disposition with a shared vision of long-term recovery. In summary, our philosophy is to provide timely intervention in a variety of community settings that promote the best opportunity for client engagement, participation, and recovery. CCBC is proposing to operate ESPs in two catchment areas the Southeast: Brockton and Taunton/Attleboro to enhance the resources of both sites with a larger pool of clinicians, peer specialists, and family partners to meet the critical demand in the Taunton/Attleboro area.

CCBC will establish an ESP that has ESP clinicians available 24/7/365 to respond to psychiatric crises in the Taunton/Attleboro catchment area. A clinician will be available from the initial phone call for triage, brief counseling, and face-to-face interventions, including evaluation, and consultation with ED staff, family, other providers and referral sources such as DMH, DCF, schools and local law enforcement. Once the evaluation is completed, the ESP team will develop an intervention that begins in the community and includes a holistic plan with the member's strengths and preferences considered at each step. With an accessible Community-Based Location, the ESP first point of contact for the client in crisis will begin in the community and not in the ED.

Based on implementation of the ESP, CCBC proposes to strengthen the model in the Taunton/Attleboro catchment area with a higher percentage of mobile crisis interventions outside of the local hospital EDs. We are proposing a community-based site with 'walk-in' capacity at the current ESP site on 108 West Main Street in Norton.

Flow of Services. From the client's perspective, contact with emergency services will usually start with a phone call to the Taunton/Attleboro community based location in Norton. However the initial contact occurs, the first priority of the ESP team is to assure client safety and the safety of those around them. Some cases are able to be resolved over the phone; others may require face-to-face crisis counseling, and some appropriate for direct admission to the CCS. CCBC believes that it can successfully triage ESP encounters and divert them from the ED, decreasing the percentage of ESP assessments conducted in EDs to below the statewide average.

CCBC's intervention model includes not only immediate stabilization of clients in crisis, but also assurance that they are properly linked to appropriate and necessary follow-up supports and clinical services. For children and their families, the Mobile Crisis Intervention (MCI) will include support for the child and family in the seven-day window following the crisis and transition to other supportive services such as In-Home Therapy. Working with people at their most vulnerable, the philosophy of the ESP is that the clinician has the opportunity to support the client in a thorough and honest evaluation of their circumstances and to match their needs to a strength-based plan for recovery in a community setting, whenever clinically appropriate. That plan draws upon holistic resources, including a seven-day intervention with children and families and direct admission to the CCS for adults. Follow-up includes securing the necessary services for a safe and timely disposition, including the search for a 24-hour program, and follow-up with the referral sources and family to inform them of the outcome. CCBC has a long track record of working closely with the entire spectrum of healthcare, behavioral healthcare, housing, and human services providers in the Taunton/Attleboro catchment area to assure that clients are able to access the care they need.

The staffing pattern for the ESP in the Taunton/Attleboro catchment area includes a 24 hour per day staffing of Masters level clinicians scheduled to respond in person within the required timeframes to the volume demands in the catchment area. All clinicians perform all of the core ESP services of crisis assessment, intervention and stabilization services listed in the MBHP Performance Specifications regardless of client location. These core clinical staff will be complemented with 1.5 FTE certified peer specialists and 1.7 FTE family partners. The entire ESP operation will be supported by a rotating group of psychiatrists totaling .8 FTE's and administrative staff to assist in scheduling and billing. The Taunton/Attleboro CCS will be staffed by a R.N. nurse manager and counselors during the day and LPN's and a Counselor on evenings, nights and weekends.

All clinicians will be available for mobile visits. Eighty percent of the clinicians will be trained to be both adult and child-family competent at the time of implementation, and CCBC intends to train and credential the remaining clinicians to be both adult and child competent within three months of implementation.

Another key element of the philosophy of the program is high visibility with community stakeholders. CCBC will complement the delivery of ESP direct services with an active presence in the community through participation in forums sponsored by DMH case managers in the Taunton/Attleboro area, the Taunton/Attleboro CSA's System of Care meeting, organized by CCBC's Community Service Agency, and community stakeholder meetings to be organized by the CCBC ESP, the Sturdy Memorial and Morton Hospital EDs. CCBC will also continue to sponsor and organize the trainings for the law enforcement and public safety personnel in Taunton, Attleboro and other towns in the catchment area through its partnership with the Taunton Community Crisis Intervention Team (CCIT). This crisis intervention training model has been a successful tool that teaches participants how to respond to the mentally ill and developmentally disabled persons that are involved with or at risk of involvement with the criminal justice system. The CCBC Taunton/Attleboro ESP will engage in joint planning with local hospitals on emergency service diversion. The presence of CCBC's psychiatrists in the current ESP and the community visibility of CCBC's CBFS program, PACT Team and Community Support Program (CSP) will support a smooth implementation of the CCBC Taunton/Attleboro ESP and engagement with community stakeholders.

How shall you change the perception which may exist in your organization and/or in your community that the ESPs function is to conduct "hospital screening"? What operational and cultural changes shall your organization make to ensure the delivery of ESP services that consist of a comprehensive and discrete level of care, incorporating crisis assessment, resolution-focused intervention, and stabilization?

CCBC will implement the ESP with the foundation that the community is the continuum of care for psychiatric interventions. The continuum includes telephone triage, open communication with the referral source as the evaluation is progressing and exploring community resources to match the member's needs. CCBC believes that this proposed model of operation of the Taunton/Attleboro ESP is congruent with the MBHP's description of the ESP service. The CCBC Taunton/Attleboro ESP will extend beyond a program that operates as a "hospital screening" program to include a continuum of care for both adults and children that offers a range of choices at each step of the crisis intervention from telephone triage to final disposition. CCBC has established an internal culture of meeting clients in a range of community settings through our Taunton/Attleboro PACT, Taunton and Attleboro CBFS programs, the area-wide CSP and the full continuum of CCBC mental health treatment programs in Taunton/Attleboro that include Day Treatment, Partial Hospitalization, and CBHI services. We see a number of opportunities for improvement in establishing the Taunton/Attleboro ESP as a continuum of care based in the community.

CCBC welcomes the opportunity to include the consumer voice in crisis intervention with the enhancement of the position of Certified Peer specialist (CPS). Including a CPS as part of the team will provide an immediate, ongoing reminder of what it is like to be on the receiving end of behavioral health services and provide an additional resource to clients in psychiatric crisis that extends beyond hospital screening and increase options for diversion. CCBC has had success with CPS and FPs by incorporating them directly into CBFS and CBHI program operations. CCBC also looks forward to creating a distinct child/adolescent Mobile Crisis Intervention team as another integrated component of CCBC's CBHI services. The MCI will include family partners as full participants on the MCI staff. The CSA already convenes Systems of Care meetings to develop and coordinate Safety Plans for families that involve the current MCI. CCBC also provides staff as MCI contracted services for the current ESPs in Taunton/Attleboro and Brockton.

Based on relationships already established in the Taunton/Attleboro catchment area, CCBC will change the perception of the ESP in the community through the active collaborations that include Task Forces, Advisory Committees, and Coalitions that address a host of social issues in Taunton/Attleboro and the rest of Bristol County. CCBC's partnerships include the Taunton Mayor's office, local police, schools, other mental health providers, mutual aid organizations, health centers, homeless shelters and the hospital EDs. As the new provider for the ESP, CCBC can approach these groups to emphasize the utility of mobile crisis outreach to meet the needs of the clients that these providers are most familiar with. New and improved visibility of the ESP to these stakeholders will provide a foundation to shifting the reliance for emergency intervention *away* from the ED to other community settings. Demonstrated ESP capacity in community settings such as homeless shelters, police stations, schools, and community health centers, among other community agencies, will also result in less inconvenience for their members.

CCBC will initiate a sustained social marketing campaign to educate clients, families, mental health providers, social service agencies, mutual aid organizations and other referral sources and stakeholders on the expanded hours and capabilities of the community-based sites and will also highlight the value of mobile crisis interventions for adults and children and their families in other community settings.

CCBC's strategy will include community meetings with key stakeholders at which concrete examples of the value of mobile crisis intervention will be shared. We will also survey the referral sources on an ongoing basis to identify the root causes of the current patterns of referral and incorporate those findings into the social marketing strategy to emphasize the capacity of the ESP to provide crisis interventions in community settings outside of the ED.

The ESP program director will organize an orientation and training protocol for the telephone triage staff to complete a standardized set of questions with the referral source at the outset in order to gather the necessary information for a resolution-focused intervention of the psychiatric crisis. CCBC will also work with the local ED staff to gather the same information. The triage staff will explore with the caller the reasons for the call, the feasibility of a mobile visit, and the source of the referral to the ESP. The ESP program director and ESP medical director will use the findings to provide ongoing discussion with all ESP staff and the referral sources about the patterns of the calls and the viability of mobile visits. The ESP managers will brainstorm methods to address the obstacles that emerge from the findings.

Finally, CCBC will provide community stakeholders with tools to effect community-based evaluations, including Wellness Recovery Action Plans (WRAPs) used for adults in the DMH service system, Safety Plans for children with SED and their families, and other outlines designed to inform stakeholders of steps to take to keep the client in a community setting. Another tool is the Community Crisis Intervention Team (CCIT) Training that CCBC has overseen successfully in partnership with the Taunton Police Department. Useful experience with these tools will provide an alternative to the default reaction of dialing 911 in a psychiatric emergency and intervention to work with the client outside of the ED.

3.1.3 Describe how you shall realize the vision and manage your ESP program, inclusive of all service components, as one integrated continuum of emergency services responsible for meeting the emergency behavioral health needs throughout the proposed catchment areas.

CCBC welcomes this RFR as an opportunity to establish a regional ESP with accompanying efficiencies in service delivery, a team of certified peer specialists (CPSs) and family partners (FPs), and a larger pool of ESP clinicians who can provide timely crisis interventions in all of the communities in the Taunton/Attleboro and Brockton catchment areas. CCBC will realize the vision of the ESP that follows from our established culture of community-based care for persons with mental illness, substance use disorders, and serious emotional disturbance. CCBC operates that model with key components that parallel the ESP requirements: flexible deployment of staff to meet fluctuating demand; skill and competency at providing an individualized intervention based on the clients' strengths, needs and least restrictive pathway to stability and recovery; capacity to deploy a team-based approach with CPSs and family partners as full participants; knowledge and familiarity with the communities in the Taunton/Attleboro catchment area to conduct safe and effective crisis interventions.

The integrated continuum of services will be enhanced with a combined Community-Based Location (CBL) and the Community Crisis Stabilization (CCS) program that will include nursing

staff will be available around the clock to check vital signs. ESP Triage staff will be available to assist CCS staff in managing behavioral crises on the unit and assisting with the treatment program involving group, individual and family counseling. All master's level clinicians, regardless of their assigned location, will function as mobile clinicians, responding to all community requests for mobile crisis intervention.

The Child Mobile Crisis Intervention (MCI) Team will have full access and back up of the entire CBL and its functions since 80% of the ESP clinicians will be child-trained at the outset and 100% within three months of implementation.

In short, CCBC views the ESP as the emergency room without walls, handling the full range of psychiatric interventions: telephone triage, mobile crisis visits, next day follow-up, linkage to ongoing treatment in the community, initiation to treatment, or disposition to more intensive 24 hour level of care treatment when indicated. The model will be enhanced with the additional support available to adults and children through the CPS and family partners as resources for the clients and their families that can contain the crises in home and community settings. This model will provide the best opportunity for a strength-based, individualized approach to clients in crisis with a greater frequency of community-based, mobile interventions outside of the ED. CCBC will realize this vision by increasing the percentage of mobile visits and strengthening links with other providers to reduce the existing practices among many referral sources of sending persons in crisis directly to the ED.

On the occasions when members are admitted to the EDs at either Morton Hospital or Sturdy Memorial Hospital, CCBC will have clinicians on site during peak demand periods to provide more responsive interventions and to build working partnerships with the ED staff.

The ESP program director will work with the CCBC quality management staff to identify key measures related to the percentage of mobile visits and timeliness of response to actively manage the pursuit of the vision. CCBC has established a strong foundation to engage in performance improvement initiatives across the agency.

3.1.4 Describe how your ESP program shall operate in a fashion that ensures fluidity among its service components, including how you shall use your staff resources in an integrated and flexible manner, while accommodating fluctuations in volume, location of services, etc. Please include your strategy to address seasonal variations in volume as well as variability among shifts.

As mentioned in 3.1.3 above, ESP staff will be cross-trained to provide interventions to both children and adults and to cover both catchment areas as needed based on fluctuating demand. Any staff member can offer real time assistance and fulfill the functions of the various components on an as needed basis. CCBC is also proposing to create "*hybrid*" positions that cover all seven days of the week and that can be shared at both sites. These hybrid staff will be hired at reduced level salaried positions with full time benefits and will receive additional payment for each evaluation completed. CCBC retains these staff by paying them a case rate in addition to their base salary, giving them an incentive for efficient responsiveness, while at the same time containing costs. They can respond to peaks in volume for children or adults in both catchment areas when there are staff shortages, high client volume, or combinations of both.

From consultations with other ESPs that have developed this model, the effect of such positions will have a positive impact on the ESP operation in the Taunton/Attleboro catchment area. First, the client will benefit from a quick response. Second, the hybrid staff member will be employed with full benefit structure. Third, the teams as a whole will be less stressed by

inevitable staff vacancies and spikes in client volume which, without such a "safety net," have the potential to exact a toll on staff morale and productivity. This "*fire-house*" model will allow CCBC to be responsive within the expected timeframes on a day-to-day basis, and will add stability and continuity to the program and strengthen CCBC's capacity to provide high quality, consistent service. An effective crisis clinician needs to have their basic hierarchical needs of safety, predictability and security met, so they can meet the needs of population in the Taunton/Attleboro catchment area requiring crisis intervention.

CCBC will also employ a "*courtesy*" evaluation strategy for peaks in volume. This is a system wherein the agency will have a protocol to tap into our existing staff roster by calling ESP staff who are off duty, but who may be available and interested in responding to a case or two for an established case-rate of pay. Similarly, CCBC has an extensive roster of appropriately trained adult and child clinical staff on which it can draw to augment the ESP clinical staff on nights, weekends and during periods of unusual heavy demand. These mechanisms will allow us to be creatively responsive to client need.

The CPS can facilitate skill building in systems navigation and development of coping skills for CCS clients in group counseling sessions and also engage in peer counseling and support for walk-ins to the Community-Based Location. CCBC has established training, orientation, supervision and other supports for peer specialists in their PACT, CBFS, and Day Treatment programs that will include the ESP as part of the implementation.

Our strategy for addressing seasonal fluctuations in Taunton/Attleboro involves several elements. First, CCBC's Human Resources Department and the ESP program director will add on-call and relief staff during the October to mid-December and mid-January to May time periods when volume tends to escalate the most. Second, the Taunton/Attleboro ESP program director will proactively meet with high volume referral sources to identify any preventive steps that can be taken with ESP staff, including peers, to keep the client safe and stable in his/her home environment and reduce the need to refer the client to either Morton Hospital or Sturdy Memorial Hospital ED. Finally, the ESP clinicians will notify the ESP program director and ESP medical director when any high-profile, high-risk, or complex cases are first evaluated so that the MCE, state agency representative, MassHealth, and key stakeholders can be brought into a clinical discussion around disposition before the client has experienced an extended stay in the ED. Examples of these types of cases include persons with serious and persistent mental illness who have recently been released from prison, children with developmental disabilities and co-occurring serious emotional disturbance; and juveniles committed to DYS for violent offenses presenting with suicidal or homicidal ideation.

3.1.5 Describe how your ESPs 800 number and triage function shall operate, noting any variance by time of day or day of week.

CCBC will establish a "*Centralized Triage* "function based on other innovative models in current ESPs. An ESP clinician will be available to answer the phone to initiate telephone triage 24 hours per day, seven days per week, 365 days per year. We propose to manage calls during normal business hours at the Taunton/Attleboro Community-Based Location from 8am–8pm, Monday–Friday. Initial triage during the day shift will be handled by an experienced BA-level staff, with immediate back-up from on-site ESP licensed clinicians. During evenings, there will be one ESP clinician at the Community-Based Location and one Clinician at one of the Hospital EDs. After hours all calls are answered by a licensed clinician as part of the Taunton/Attleboro ESP. If all three clinicians are involved in a face-to-face evaluation, the calls will be

automatically routed to the Brockton ESP and are answered by an on-call licensed Clinician. As noted in the previous section, there is at least one licensed clinician available to receive calls 24 hours a day, 7 days per week, year round.

Clinicians staffing CCBC's ESP will have 24/7/365 access to the ESP program director, the ESP clinical supervisor, and psychiatrist through an on-call system. These staff will respond to all pages within 15 minutes per the MBHP performance specifications. The CCBC psychiatrists also work in other CCBC programs, including PACT, Day Treatment, CBFS, and Outpatient settings and are familiar with the CCBC client population. The Taunton/Attleboro ESP will operate an "Administrator-On-Call" (AOC) rotation with supervisory back-up 24/7/365 for ad hoc clinical supervision from a clinical manager on-call and a psychiatrist to help with resolution of "systems issues" and complex clinical presentations. This Central Triage will cover both the Taunton/Attleboro and Brockton catchment areas to ensure timely access to an expanded pool of clinicians and centralizing critical information in one agency. MBHP will gain efficiencies and consistency in operations with a regional approach.

3.1.6 Geographic coverage; Does your organization have resources such as various locations you can leverage, as part of your strategy?

CCBC has three office sites in Taunton/Attleboro and numerous staff who already work in the Taunton/Attleboro Outpatient, CBFS, PACT, CBHI and CSP programs. In some instances, clinic sites in Taunton and Attleboro can provide better access than the Community-Based Location in Norton. Some of these staff can function as ESP relief clinicians to supplement ESP staff. In addition, CCBC is proposing a single administrative structure to the ESPs in Taunton/Attleboro and Brockton to provide additional resources and administrative efficiencies to the Taunton/Attleboro catchment area.

The CCBC ESP Community-Based Location will share a co-location with the Taunton/Attleboro CCS program. The communities in the Taunton/Attleboro catchment area do not require long travel times from the Community-Based Location in Norton.

3.1.6.1 The location of the Community-Based Location at 108 West Main Street in Norton, Massachusetts will ensure that all mobile visits in the catchment area available within a 30-minute drive.

CCBC will develop creative staffing strategies involving hybrid clinicians described in section 3.1.4 and placement of clinicians at the Morton Hospital and Sturdy Memorial Hospital EDs during certain weekday evening shifts to address the fluctuations in volume as the need arises. CCBC will have the capacity to respond to any "hot spots" in the Taunton/Attleboro catchment area, including the hospital EDs, with an expanded roster of ESP clinicians from two catchment areas, if needed, that will meet or exceed the response time standards established in this RFR. As noted above, CCBC has a roster of dozens of clinicians with the necessary training including supervisory staff to back up dedicated ESP staff to assure timely response and exceed MBHP performance standards particularly during peak demand and during any start-up period.

3.1.7 The regional approach proposed by CCBC will assure MBHP of a consistent approach for the Taunton/Attleboro and Brockton catchment areas.

CCBC will also address the high volume demand at the two hospitals in the Taunton/Attleboro area, Morton Hospital and Sturdy Memorial Hospital, with a clinician available to be posted at one of the Hospital EDs from 3-11pm for up to five days per week, Monday through Friday, and available to be on-site as needed during peak demand times on

weekends and holidays. These clinicians can be deployed elsewhere in the catchment area to provide mobile crisis interventions upon request form the Triage Clinician.

3.1.8 Location of services:

3.1.8.1 Please provide general information about the planned location(s) of ESP functions and services as well as hours of operation:

Service Component	Address(es) where Service will be Delivered or Dispatched From	Days/Hours of Operation		Other Services at this Location
		Of the service component	Of the **Physical site**	
ESP Management Function	**Executive Management**: CCBC Taunton Main Office 1 Washington Street, Taunton **Program Management**: 108 West Main Street, Norton	8:30am–5pm, M–F	8am–8pm 24/7/365	CBFS, CBHI, PACT Outpatient CCS, MCI, CBL
1-800 number and triage	**Taunton/Attleboro CBL**: 108 West Main Street, Norton	24/7/365	24/7/365	CCS, MCI, CBL
Community-based location	**Taunton/Attleboro CBL**: 108 West Main Street, Norton	8am–8pm, M–F	24/7/365	CCS, MCI
Youth Mobile Crisis Intervention	**Taunton/Attleboro CBL**: 108West Main Street, Norton and from CCBC Main office as needed for back up volume	24/7/365 24/7/365	24/7/365 8am–8pm, M–F	CCS, MCI
Adult Mobile Crisis Intervention	**Taunton/Attleboro CBL**: 108 West Main Street, Norton and from CCBC Main office as needed for back up volume	24/7/365 24/7/365	24/7/365 8am–8pm, M–F	CCS, MCI, CBL
Adult CCS	**Taunton/Attleboro CBL**: 108West Main Street, Norton	24/7/365	24/7/365	CBL, MCI
RAP	**Taunton/Attleboro CBL**: 108West Main Street, Norton	4:30am–8pm, 24 hours weekends and holidays	8:30am–8pm, M–F	CBL, CCS, MCI

3.1.8.2 N/A. CCBC leases the current Community-Based Location at 108 Main Street, Norton.

3.1.9 ESP management

3.1.9.1 Please attach resumes, or if not yet hired, please describe hiring qualifications of the following positions:

3.1.9.1.1 ESP program director
3.1.9.1.2 Quality/Risk Management Director
3.1.9.1.3 Medical director

3.1.9.2 Attach an organization chart that indicates where these and other key ESP staff shall sit within the organization at an administrative and supervisory level.
3.1.9.2 – See Attachment 3.1.9.2

3.1.10 Psychiatry: Describe your plan for psychiatry staffing and ensuring that all performance specifications related to access to adult and child psychiatric consultation and direct services, in all ESP service components, are met 24/7/365.

CCBC will appoint Paul Weiss, MD as ESP medical director to oversee the rotation of on-call psychiatrists in Taunton/Attleboro and also in Brockton. Dr. Weiss is currently serving as the contracted Emergency Psychiatrist to the Taunton/Attleboro and Brockton ESPs operated by DMH. He will provide clinical supervision to the on-call psychiatrists, the nurse manager in the CCS, the ESP program director and program manager for MCI. He will also sit in weekly clinical rounds at the ESPs and CCSs in the Taunton/Attleboro catchment areas one morning per week. Other duties include acting as the clinical liaison to Emergency Department physicians and community primary care physicians and participation with the program director in the regular meetings with the ED administrators.

CCBC has a rotating on-call system of psychiatrists who work for CCBC community-based programs, including the DMH-Operated ESPs. The doctors are required to respond to all calls from the ESP within 15 minutes, but CCBC expects them to respond within 60 seconds, almost 100% of the time. CCBC believes that the model of having a single doctor on-call in both catchment areas for case consultation will be a better use of limited resources across the two catchment areas. We believe that a consistent clinical approach across the two catchment areas will add value to the ESP model that CCBC is proposing. As ESP medical director, Dr. Weiss will provide back up to the on-call rotation for both adults and children.

In an effort to increase the frequency of community-based mobile crisis interventions and use of alternatives to inpatient hospitalization, the medical director will chair a team to review and update the clinical criteria for diversion from the ED and from inpatient hospitalization. He will work with Morton and Sturdy Memorial Hospital staff to formalize a protocol for urgent psychopharmacology consultation for clients in the ED. The medical director will also be available for review of mobile requests.

The medical director will serve as the primary contact person in the ESP to provide a clinical resolution for clients who have remained in the ER or on a medical floor for more than 24 hours. An inherent strength of the CCBC system is the presence of psychiatric staff in various programs. The Board-certified child psychiatrist on-call function will be fulfilled by existing CCBC child psychiatrists. All psychiatrists meet MBHP credentialing criteria.

3.1.11 Strategies to Assess Risk

CCBC ESP staff will all be trained in completing core elements of a risk assessment from the initial telephone contact to the completion of the intervention. Often the telephone contact comes from a family member or provider. The Triage clinician asks critical questions about severity of symptoms, presence of weapons, recent use of alcohol or drugs, history of violence and any immediate injuries or threats of injuries to the client or those in the immediate vicinity.

CCBC will develop a "*decision tree*" that their telephone triage and front-office staff will deploy to provide an initial risk assessment. This decision tree covers: signs of intoxication; any external reports of danger posed by the client to others or to him/herself; the current level of ideation of self-harm; the willingness of the client to engage with ESP staff on discussing his/her mental state; and to contract for safety and to transport him/herself safely to the location where the evaluation will be completed. The CCBC protocol also includes questions on the client's strengths and preferences.

In person, the ESP clinicians complete a standardized risk assessment form that covers the following: the client's current mental status; treatment history; current collateral contacts; the CCBC clinical history and medical record review; the nature of the presenting problems; and current stressors. For children, CCBC conducts a joint interview and separate interviews with the child and guardian based on the age of the child and the nature of the problem.

At each stage of the interview process, the CCBC clinician re-confirms the client's consent for treatment and their goals for the crisis intervention.

CCBC triage will go beyond the requirements of the RFR to consider with the client the possibility of the ESP clinician conducting the assessment in the client's community setting even when the client is not willing. The ESP medical director will oversee the established protocols to work with local police and families to decide on a case-by-case basis if a mobile visit is safe and warranted on a non-voluntary basis. The ESP will have the capacity to assign additional staff in these cases.

CCBC will continue to refine and centralize policies and procedures to guide the Triage staff and ESP clinicians in decision-making on mobile crisis interventions that address the key risk and safety issues for community-based ESP services. The consistent application of these practices across the Southeast region will minimize risk for the clients and their families.

Strategies to Mitigate Risk

CCBC will deploy a host of strategies to mitigate risk during the course of a crisis intervention at the CBL. Most importantly, ESP staff, along with all other CCBC staff who work in the community, will carry electronic safety devices that alert supervisors and colleagues and emergency responders if necessary, if the employee is in any type of danger or requires back up or consultation. Currently CCBC has distributed over 250 of these devices (5 Star by Great Call) to CPS, CBFS, CBHI and PACT staff.

There are three steps to mitigate safety risks in the ESP evaluation process: First the ESP clinician will clarify the client's consent for treatment at each stage so that there is open and ongoing communication even when the clinician determines that an involuntary intervention is required for safety reasons.

Second, when the clinical staff believe that the physical presence of the safety staff will provide stability and calm for an agitated client in a community-based location, CCBC will deploy additional staff including certified peer specialists and family partners.

Three, in limited circumstances, the hospital ED will be used due to availability of security staff, or local police will be asked to accompany clinical staff.

Finally, the ESP medical director or his designee will review all cases that are diverted from 24-hour care back to a community setting to ensure client safety, as well as the safety of others.

3.2 Community-based location

3.2.1 Describe your ESPs proposed community-based location(s) including:

3.2.1.1 General description of the physical plant, include parking, signage, entryway, waiting areas, treatment areas, meeting space, and staff work areas

The site is located at 108 West Main Street, Norton, on Route 123, mid-way between the population centers of Taunton and Attleboro. This location provides access from any of the towns in the Taunton/Attleboro catchment area. Community Counseling of Bristol County, Inc. (CCBC) currently leases this property which the Department of Mental Health's (DMH) Taunton/Attleboro Emergency Services Program (ESP) occupies. The property houses both the child and adult Mobile Crisis Teams and the Community Crisis Stabilization (CSS) unit which consists of seven beds. The building was designed and built for the Emergency Services Program and as a result it is well suited for the functional demands of the ESP.

The property encompasses 3,800 square feet and includes office space sufficient to both accommodate program staff and provide at least three rooms to conduct client interviews. The wing in which the CCS is located includes a dining room, living room, and a kitchen. The entire building is handicapped accessible and there is ample parking. The building remains under lease and can be occupied as soon as DMH vacates the property.

3.2.1.2 One Hundred Eight (108) West Main Street is located mid-way between the two most populous areas – Taunton and Attleboro and thus provides the best access for members from each community, as well as the other towns in the Taunton/Attleboro catchment area.

3.2.1.3 One Hundred Eight (108) West Main Street, Norton is located mid-way between the two most populous communities in the catchment area.

3.2.1.3.1 ***Letters of Support Attached***

3.2.1.4 Proximity and access to public transportation. The Community-Based Location on 108 West Main Street in Norton is located on Route 123 and is serviced by the Greater Attleboro/Taunton Regional Transit Authority (GATRA), as well as local taxi services. The closest stop to the CBL is the Norton Post Office, which is .8 miles away. Staff of the ESP will be mobile and available to transport clients to and from EDs or from the bus stop.

3.2.1.5 CCBC will have mild and calming colors on the walls with recovery-oriented and strength-based posters complementing any artwork hanging on the walls. The message of the posters will communicate hope.

All staff will be trained in motivational interviewing, client engagement and customer service skills to make sure the clients, their families, collateral providers and other parties are treated with respect, dignity, and the right to determine the course of their care and recovery to the maximum extent possible. Staff will repeatedly ensure that all persons who come to the ESP are oriented to the specific features of the program beginning with initial contact. Staff will explain the steps to be taken during the ESP episode: initial information gathering, clinical assessment, plan of action developed with the client, and placement or discharge with identification of the necessary resources. The staff person will also provide an initial estimate for the length of time for each step of the ESP process. The client will also be made aware of the resources of the ESP, including an offer of support from a peer specialist or family partner to provide further explanation of the ESP process.

Staff will underscore the member's right to confidentiality, and, while emphasizing the importance of talking to collateral providers, acknowledge the member's right to refuse the ESP to contact other parties and that only written permission will suffice once verbal permission is obtained.

3.2.1.6 CCBC staff will ensure that any client or family member coming to the Community-Based Location (CBL) is fully oriented to the nature and purpose of the ESP and repeat such clarifications as needed during the member's visit.

CCBC recognizes that emergency services staff will usually be encountering clients at moments of heightened vulnerability. To be effective, staff must rapidly engage the client, and develop a rapport. A potential problem arises if the client decides that their ESP clinician is the only one that can help them. Staff will be very clear that their role is to support the client in achieving equilibrium and staff will communicate openness to the client's individual needs and preferences to address any acute psychiatric symptoms. On some occasions staff will need to set firm, but caring limits, particularly with that sub-set of clients that use the service and want ongoing support. A key in such situations is to use the techniques of motivational interviewing to align with clients on follow-up with community-based services. Indeed, linking the client to the appropriate community-based services is the primary goal of the ESP post-stabilization.

All staff will be trained to follow a standard protocol that results in a consistent message to the client: the ESP is for crisis intervention, stabilization and follow-up to the services that match the client's needs; that the client will be informed and have choice about that service; that staff will keep lines of communication open to the client, his/her family as appropriate and for adults, when consent is given by the client, regarding next steps and available support for the client; and finally, that the client has access to a clinician, a peer specialist or family partner for the parent of a child, and that staff have access to consultation from a clinical supervisor, nurse and psychiatrist on-call if the need arises.

3.2.2 Describe how you shall utilize your community-based location(s) to achieve the goals of ESP and this procurement, including:

3.2.2.1 How the selected community-based location shall support the goal of diverting behavioral health utilization from the hospital EDs in the proposed catchment area

The Community-Based Location is located mid-way between Taunton and Attleboro and will be open from 8:00 a.m. 8:00 p.m. Monday through Friday with the adjacent CCS open 24/7. The ESP will promote the Norton site as an alternative to the local EDs and as indicated will transport clients from the EDs to the CBL for assessment.

3.2.3 Staffing

3.2.3.1 Describe how the staffing in your community-based location shall be used flexibly to meet the needs on a daily basis, including integration with the adult CCS.

The CCBC Taunton/Attleboro ESP will develop a model of flexible deployment of staff in the Taunton/Attleboro catchment area. CCBC is planning the features and benefits to assist MBHP in reducing reliance on the two EDs in Taunton/Attleboro, increasing mobile crisis interventions in the community and accessing a wider range of community-based alternatives to hospitalization. There are several highlights to the operation of this design that maximize flexibility and promote responsiveness to referral sources for crisis interventions:

- The co-location of the Taunton/Attleboro Community-Based Location (CBL) with the CCS at 108 West Main Street, Norton, will allow for staff from the CCS to assist staff assigned to the CBL during high call volume and demand for crisis interventions, staff shortages or acute client episodes within the CBL. Similarly, staff in the CBL can assist staff in the CCS when there is higher than normal acuity or when clients' symptoms become more acute or disruptive in the CCS setting.

- Staff who are placed on-site at either the Morton or Sturdy Memorial Hospitals' ED during evening shifts are not precluded from being re-assigned by the Triage clinician to another site or to a mobile crisis intervention.
- The "hybrid" clinician position ensures additional staff during high volume periods of late afternoon early evening with a staff person who is available outside of the normal staff complement.
- CCS staff may be used for phone coverage, transportation to and from sites, and safety for office-based visits as part of de-escalation interventions.
- The peer specialists and family partners are available to accompany ESP clinicians for mobile visits.
- The administrative staff at both CBLs will be skilled at completing the administrative tasks that are often time-consuming in completing a crisis intervention. Their ability to communicate client status, verify insurance, respond to calls regarding a hospital search, and connect with collateral providers and family members, enables the ESP clinician to spend more face-to-face time with the client and the family completing the assessment and de-escalating the crisis.
- Eighty percent of current ESP clinicians will be cross-trained to work with children and families at the time of implementation. Within three months, 100% of ESP staff will be able to support the Youth Mobile Crisis Team.
- CCBC will draw upon its roster of experienced clinicians throughout the organization to assist in providing a rapid response during periods of unanticipated heavy demand.

3.2.3.2 Describe how you shall utilize Certified Peer Specialist staff in your ESP community-based location(s).

The Taunton/Attleboro ESP will work closely with the CPS to define and refine their role with the ESP. At the outset, however, we envision some key functions for the CPS:

- The CPS can provide peer support for clients who are especially withdrawn or perhaps somewhat agitated to assist the clinician in engagement and to provide reassurance during the period that the ESP and the client are awaiting a resolution to the intervention.
- The CPS can assist in the interview to help the clinician in understanding the client's symptoms and answers if the client is especially agitated. Sometimes an informal approach by the CPS may yield better results, and the client may share more if they know that the peer may have gone through similar struggles.
- The CPS can provide same day or next day follow-up to the client in assisting them with intake appointments, securing of basic necessities, applying for benefits, or attending local self-help programs.
- The CPS can accompany the ESP clinician on MCI visits as a "safety" staff person and to help in gathering information from family members or the referring provider.
- The CPS will run peer support groups in the CCS for interested clients to help them build coping skills and help them learn to access community resources including 12-step recovery programs, housing, entitlements and social supports.

3.3 Adult Mobile Crisis Intervention

3.3.1 Provide a brief program description that summarizes your planned Adult Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

3.3.1 CCBC's proposed model of operating the Taunton/Attleboro ESP will ensure a consistent application of MBHP performance specifications. This approach will enhance timely telephone triage, responsive program management, comprehensive clinical supervision, and access to risk management and quality improvement resources that will result in a higher quality of care, more efficient use of resources, and more timely achievement of MBHP goals. This structure will ensure a higher rate of mobile visits, higher rate of diversion from inpatient hospitalization and more timely responses to requests for ESP interventions.

Program Philosophy and Culture. The philosophy of CCBC's Taunton/Attleboro ESP is that rapid response to urgent care situations increases community-based interventions that lead to greater rates of diversionary disposition, therefore ESP staff will quickly determine at the initial phone triage the feasibility of an adult mobile crisis intervention through a telephone assessment by the experienced triage staff. They will work with the referral source to assess the utility of a mobile crisis intervention based on the client's willingness, the current risk and safety issues, the availability of family, friends or providers to assist, the need for police assistance, and any outstanding medical issues that would contraindicate a mobile visit. Other factors include CCBC's working familiarity with the referral source and the client's involvement with CCBC services including the client's prior ESP episodes both of which will be available to the Triage clinician through the CCBC Electronic Health Record (EHR) system. The ESP will also have access to any standing crisis plan with current providers, such as the CCBC Risk Management Team.

Service Delivery Model. When the telephone Triage clinician decides on a mobile visit, s/he can immediately dispatch one of the available clinicians to the location. There will be a "*white board*" in the office that specifies the location and activity of all ESP clinicians on duty. The Triage clinician also has a roster of the hybrid clinicians and the other ESP relief clinicians who can be contacted if all of the clinicians on duty are involved in other crisis interventions. All master's level clinicians are available for mobile crisis interventions. With an adaptation of CCBC's EHR, CCBC will incorporate a computer tracking and scheduling system to monitor requests and response times throughout the two catchment areas.

Flow of Services. CCBC ESP managers and supervisors on-call will determine the support for the ESP clinician in the mobile setting. A mobile visit to a private home is likely to often involve two ESP staff. Visits to group homes, schools, local jails, and nursing homes will usually require only the ESP clinician unless the client or family requests a CPS or FP.

3.3.2 Describe how you shall utilize bachelor's level staff and/or Certified Peer specialists to support the adults utilizing these services and to assist the master's level clinicians in providing ESP services to adults in a mobile capacity.

The use of the BA and CPS staff for Mobile Crisis Interventions will follow the same protocol as the determination of mobile visit from the outset. For example, some clients prefer the presence of a CPS in their self-determined crisis plan. Other clients may prefer to have a person, who has similar experiences as the client in a crisis, accompany the clinician. CCBC also knows from experience that the BA-level or CPS can be a stabilizing influence on the client by taking time to explain to the client or sit with the client while a follow-up service is being

located. The addition of these staff may also be preferred by the family member or referral source. The Triage clinician will consider all of these factors in assigning a BA staff person or CPS to accompany the ESP clinician in a mobile crisis intervention. It is CCBC's goal to have the CPS fill the BA-level staff positions as well as the CPS positions. CPS staff can also be useful in keeping the family informed about the status of the assessment and answering their questions.

3.4 Adult Community Crisis Stabilization (CCS)

3.4.1 The goal of CCBC's CCS program is to stabilize clients experiencing a behavioral health crisis that might otherwise deteriorate to the point of needing hospitalization. The program shares several features with an inpatient setting: a multi-disciplinary team approach, a staff secure setting with around-the-clock presence of nursing and counseling staff, low client/staff ratios, a separate living environment that affords a respite from daily life, and the capacity to prescribe and monitor psychotropic medication.

Clients admitted to the CCS will participate in an organized program of individual and group counseling, peer support, medication education and case management. The goal of the client's participation in the program is to enhance their existing strengths, stabilize their psychiatric symptoms, coordinate with existing supports in the community, and prepare the client for a timely return to their community setting. All clients will receive an initial bio-psychosocial assessment that includes an evaluation of current medications. Each day the assessment will be updated throughout the client's stay in CCS.

At the outset of the ESP intervention, the program philosophy will be to rule in all adults for admission to the CCS when the client requires a safe placement. This includes persons with active substance use issues and persons who present some risk to themselves or others. CCBC triage staff will then rule out admission to the CCS if the client's mental health requires the presence of skilled nursing staff around the clock, if a locked setting is required to prevent the client from harming him/herself or others, or if there are other medical conditions including detoxification that require monitoring by skilled medical staff around the clock.

CCBC will provide 24/7 awake staffing of the CCS with a minimum of one LPN and one BA counselor or safety worker on site for all shifts. During the day and evening shifts, the clients will participate in structured activities including medication education groups, self-help groups on building coping skills (facilitated by the CPS), discharge planning groups, and recreational activities. Staff will also provide case management activities with clients to assist them on making arrangements for follow-up care and other necessary resources such as housing, entitlements, court appearances, medical appointments, and accessing natural community supports.

Each client will have an assigned counselor who will oversee their participation in the program and work with the client on discharge planning, crisis planning, contacting current providers, arranging for intake appointments with new providers, and helping the client to identify and follow-up with holistic resources and natural community supports identified to be a part of the client's continued recovery.

The ESP psychiatrist will review and approve all admissions in consultation with the Nurse Manager and participate in medication evaluations as needed. The ESP psychiatrist will approve all CCS discharges.

3.4.2 Physical plant

3.4.2.1 General description of the adult CCS's space, including treatment areas, living space, meeting space, staff work areas, and parking

CCBC proposes to co-locate its ESP CBL and CCS at 108 West Main Street in Norton, the current location of the DMH ESP in Taunton/Attleboro. The site is located on Route 123, mid-way between Taunton and Attleboro. This geographically centralized location is equally accessible to clients, families, and staff across the entire catchment area.

The building is handicapped accessible and there is ample parking. The building meets all fire and safety code requirements. The property houses both the child and adult Mobile Crisis Teams and the Community Crisis Stabilization (CSS) unit which consists of seven beds. The building was designed and built for the Emergency Services Program, and as a result it is well suited for the functional demands of ESP.

The property encompasses 3,800 square feet and includes office space sufficient to both accommodate program staff and provide at least three rooms to conduct client interviews. The wing in which the CCS is located includes a dining room, living room and a kitchen. The building remains under lease and can be occupied as soon a DMH vacated the property.

3.4.2.2 How you shall establish a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support

The CCS will have warm, calming colors on the walls with posters that provide hope, encouragement, and examples of recovery for the residents. The rules of the program, client rights, and daily schedule will also be prominently displayed so that clients are fully aware of their responsibilities and obligations in the program.

Staff will be trained in motivational interviewing, clarity of communication, and in holistic approaches to psychiatric interventions. The peer specialists will be part of the orientation for staff and will also be available to clients who seek informal communication to share any concerns about the program.

3.4.3 State your plan related to co-location of the adult CCS with the ESP community-based location

CCBC holds the lease on the space at 108 West Main Street that houses both the Community-Based Location and the CCS. There will be no delay in co-location of the community based location with the CCS at the time of implementation.

3.4.3.1 Describe the co-located or shared space relative to proximity, flow, and any space that shall be shared for functions of both the ESP and adult CCS.

CCBC is the current lease holder of the space of the DMH-operated ESP at 108 West Main Street. This space provides ready access between the CCS and the CBL for maximum flexibility in staff deployment. This facility was constructed explicitly for the CBL and CCS services and meets the need for both components. Reception, staff offices and meeting space are shared between the CBL and CCS.

3.4.3.2 The space is already set up for co-location of the CBL and CCS.

3.4.3.3 N/A

3.4.4 Changes in CCS Capacity

CCBC proposes no changes to the capacity of the CCS in the Taunton/Attleboro catchment area.

3.4.5 What is your proposed communication plan between your adult CCS and your other ESP service components, particularly your ESP community-based location, for example, staffing, sharing resources, transfers, sharing clinical knowledge, risk management/safety planning, joint rounds, joint staff meetings, etc.?

CCBC is proposing to locate the telephone triage and CBL for the Taunton/Attleboro catchment area in the same building as the CCS. The location of all staff on duty is listed on a white board. Triage clinicians have authority to call in additional clinicians and BA-level staff when the need arises.

The ESP medical director and the nurse manager of the CCS, who is director of the program, will work collaboratively with other ESP staff or psychiatrist in reviewing client records daily on all CCS admissions. The nurse manager will conduct daily rounds for CCS clients. All CCS staff can follow-up with ESP clinicians who completed the initial ESP assessment if there are any questions Psychiatrists will review each CCS client with the psychiatrist replacing them on care.

At weekly staff meetings of all ESP staff, case presentations will be discussed to determine the appropriateness of members referred to CCS in line with risk management criteria around safety. A portion of the staff meeting will include joint rounds to identify challenging and successful cases where CCS was an appropriate diversion or when a CCS admission could not be managed in the CCS.

On a monthly basis, the ESP program director will invite representatives from Morton Hospital and Sturdy Memorial Hospital EDs to participate in case reviews that involve members referred from EDs to CCS.

3.4.6 Describe your planned approach to utilize the full clinical potential of the adult CCS outlined in this RFR and the performance specifications. Address how shall you educate stakeholders of the capacity and acuity level of the adult CCS and how shall you make consumers, families, and other stakeholders feel comfortable using the adult CCS to treat those who present with a higher level of acuity.

Based on the experience of the CCBC-contracted psychiatrists providing clinical oversight to the DMH-operated CCS programs, CCBC will continue to build the culture within the ESP so that the CCS can manage an increasingly challenging client. The CCBC psychiatrists who are contracted to work with the DMH-operated CCS's in Taunton/Attleboro and Brockton have developed a close working relationship with the nurse manager in charge of each CCS. Together they have developed a philosophical commitment to serving those most in need, and track record of eliminating barriers to access. The first objective will be to review the clinical criteria and admission process to identify any obstacles to timely access. Among these are required medical clearances that may or may not be necessary. The second objective is to train all staff, including staff in the CBL, on the admission criteria, admission process and approval of admissions.

As a new provider for ESP and CCS services in the Taunton/Attleboro catchment area, CCBC recognizes that much work with stakeholders will be necessary to build an acceptance of the full capacity of the CCS. There are several steps that CCBC will take to demonstrate the capacity of the CCS: First, the admission criteria and steps to the admission process will be distributed to all clinical referral sources, including hospital EDs, Manet Community Health Center, other outpatient mental health centers, CCBC staff, DMH Case Management staff, local ambulance companies, as well as law enforcement officials. The second step will be face-to-face meetings with examples of recent referrals that were admitted to the CCS to provide a context for the referral sources, as well as examples of clients. Third, the ESP program director and CCS

nurse manager will host a series of open houses at the CCS to encourage stakeholder to view the physical setting and meet the direct care staff.

Once the CCS has been operating, the ESP program director will assign staff to work as "*ambassadors*" to community programs such as nursing homes, group residences, shelters and community support programs, whose clientele can most benefit from the CCS as an alternative to hospitalization. CCBC's social marketing efforts will tout the benefits and the capacity of the CCS to other providers as well as to ED medical staff and police. The ESP will also hold informal "*open houses*" for community stakeholders to visit both the central triage and the CCS.

3.5 Mobile Crisis Intervention (MCI) Response Section

(Note: An incomplete or unsatisfactory response to this element could exclude a bidder's proposal from consideration.)

3.5.1 Statement of intention:

X The bidder intends to directly operate the Mobile Crisis Intervention component of the ESP and shall demonstrate competency in the section that follows.

N/A The ESP intends to enter into a subcontract arrangement with another entity that meets the requirements of subcontractors outlined in Section V.C. of this RFR. Enter the name of the agency (additional information will be requested in narrative response section 4.3. below). The competency of the proposed subcontractor agency is demonstrated in the section that follows.

3.5.2 CCBC believes that we are well positioned to exceed the MBHP Performance Specifications of the MCI Program in the Taunton/Attleboro catchment area because of the following:

1. CCBC has two years of experience as the contractor for MCI services to the DMH-operated MCI Team.
2. CCBC is the CSA for the Taunton/Attleboro catchment area. We are the leader in delivering and promoting the Wraparound Model of care that is integral to the delivery of Mobile Crisis Integration along with other CBHI services. The CSA also hosts the Systems of Care meetings in the area, at which Safety Plans for children with SED and their families are developed to manage psychiatric crises.
3. CCBC has 12 years of experience as the contractor for Emergency Psychiatric Services with the DMH-operated ESP team in Taunton/Attleboro.
4. CCBC's CBHI services have recruited Family partners over the past six year. They have fully integrated them into the CBHI service delivery model. Incorporating them into MCI will be a seamless process. Currently CCBC employs 10 family partners.
5. CCBC's Taunton/Attleboro CSA is the lead behavioral health provider for Bristol County's Juvenile Justice Behavioral Health Alternative Path Program (JJ-BHAPP).
6. The operation of the CSA and other CBHI services is continuously being improved through a robust quality improvement process based on feedback from families and standardized measures of wraparound fidelity. This CQI process will include the Taunton/Attleboro MCI program.
7. CCBC has a solid foundation in Taunton/Attleboro as a provider of Child Outpatient mental health services, CBHI services, such as In-Home Therapy and Therapeutic

Mentoring, as well as the established Community Service Agency (CSA) for the Taunton/Attleboro area.

8. CCBC is the Runaway Assistance Program (RAP) lead for all of the Southeastern Area for DCF that includes the Taunton/Attleboro area.

3.5.3 Further demonstrate your organizations (or proposed subcontractor's) readiness to provide Mobile Crisis Intervention by attaching the following documents (as many as are available and applicable to your organization) in order to demonstrate meeting the criteria delineated in Section V.B. of this RFR:

3.5.3.1 Below are examples of CCBC's experience with key measures of competence for an MCI Program:

- CCBC serves 3,000 children annually in our outpatient mental health clinics.
- CCBC serves 900 children annually in our full spectrum of CBHI Services: Intensive Care Coordination, Family Support and Training, In-Home Therapy and Therapeutic Mentoring.
- CCBC employs 10 family partners in its CBHI programs. One of these family partners also works for the DMH-operated ESPs as one of the family partners.
- CCBC's CSA is fully compliant with MassHealth CBHI performance specifications in the use of Strength-Needs-Cultural Discovery Assessment Form, in developing Crisis Management Plans with families, scoring on the Wraparound Fidelity Index (WFI) and Team Observation Measures (TOM), and Family Satisfaction survey results on families being included in service planning.
- CCBC's CSA meets twice a year with the MCE network managers, a proxy for compliance with existing standards of care related to access, quality and outcome.

3.5.3.2 CCBC is fully compliant in training all staff on the Principles of Wraparound Systems of Care. Staff receive ongoing coaching and training to maintain and improve skills. ***See Attachment 3.5.3.2 for evidence from the Wraparound manual indicating CCBH's compliance.***

3.5.3.3 Evidence of working with Family and Youth: ***See Attachment 3.5.3.3on FY 2014 Report on Family Satisfaction Survey and key findings from FY 2015 survey.***

3.5.3.4 Policies and Procedures and/or Clinical Protocols. ***See Attachment 3.5.3.4***

3.5.3.5 Outcomes Data: CBC's CSA participates in the measurement of Wraparound Fidelity Index, or WIFI, and the Team Observation Measure (TOM) with other CSA's. See Attachment on WIFI and TOM Reports in Attachment 3.5.3.5. The scores are tallied annually and CCBC uses the findings to design program improvements to better serve children and families. ***See Attachment 3.5.3.5 on FY 2014 Report on Family Satisfaction Survey and key findings from FY 2015 survey.***

3.5.3.6 Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels in providing behavioral health services to children, adolescents, and their families. Evidence may include accreditation reports that speak to your work with youth and families and in-service training schedules or curriculums addressing the assessment and treatment of youth and families.

CCBC's CSA provides a Credentialing Report to the MCE's on the staff hired as intensive care coordinators and family partners.

The agency operates three licensed outpatient sites licensed by DPH that serve children and families. ***See Attachment 3.5.3.6 for the Wraparound Facilitator Checklist.***

3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention

3.5.3.7.1 ***See Attachment 3.5.3.7.1***
3.5.3.7.2 ***See Attachment 3.5.3.7.2***

Job descriptions of any identified staff members who would be staffing the Mobile Crisis Intervention service in any capacity, including the Mobile Crisis Intervention program manager, child psychiatric clinicians, child-trained supervisors, child-trained clinicians, paraprofessionals and/or family partners.

3.5.3.8 Experience of integrating youth and family voice in organization governance. Evidence may include names and length of service of those currently on advisory boards.

One member of CCBC's Board of Director's has a child with Serious Emotional Disturbance.

The CCBC CSA's Systems of Care Committee convenes monthly meetings that are open to all children's advocates and stakeholders in the Taunton/Attleboro catchment area. CCBC's Family partners and CSA and IHT family members in care attend the monthly statewide PPAL meetings.

The CSA director is a member of the DCF Children and Family Area Board for Children. The goal of the meeting is to provide support to DCF foster parents, help children graduating from Foster Care into independent living, and support DCF's mission overall. The CSA director is also on the Board of Associates for Human Services' Early Intervention Transition Committee for children transitioning from Early Intervention to public school. CSA has also conducted focus groups comprised of parents and guardians of children enrolled in the CSA to solicit their input into program development.

3.5.3.9 The CCBC CSA has worked with the DYS, DCF and DMH residential providers when members from their CSA are receiving 24-hour care in one of these programs. One of the key principles of Wraparound is to coordinate with other stakeholders and to empower the family to have the central voice. CCBC's CSA provides a model for other stakeholders to implement this practice.

3.5.3.10 Membership in child advocacy and/or child-focused trade organizations

CCBC is a member on the following local and statewide child advocacy and trade organizations:

- Parent Professional Advocacy League (PPAL);
- The Department of Children and Families' Area Advisory Committee;
- The Association for Behavioral Health (ABH)'s CBHI Committee and ABH's Child Policy Committee;
- CCBC attends Statewide CSA Meetings, Southeast CSA Meetings and the CSA Statewide Coaching Meetings;
- Language Access Committee in Taunton/Attleboro Area, facilitated by Associates for Human Services.

3.5.4 Mobile Crisis Intervention

3.5.4.1 Provide a brief program description that summarizes your planned Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.

Describe how you will provide a bi-disciplinary (clinician and family partner) intervention to engage and address the treatment needs of the child while also engaging, and supporting the experiences of the parent(s) whose child is in crisis.

Program Description. CCBC will implement the Mobile Crisis Intervention program in the Taunton/Attleboro catchment area to be fully compliant with the ESP Performance Specifications and consistent with the Principles of Wraparound model of care. CCBC's program philosophy underlying MCI services are embodied in the Principles of Wraparound Services. CCBC will be committed to providing 70% of the services at a minimum in the community-based settings, such as schools, homes, day care programs, after-school programs and group homes and shelter. All clients presenting for Mobile Crisis Intervention will be evaluated by the clinician who is child-competent and experienced with children and families.

MCI staff will be fully trained in the Wraparound model of care to provide a strength-based approach to children with SED and to their families. Their approach to family engagement and empowerment and a child's resiliency will increase the use of the full continuum of community-based alternatives in the Taunton/Attleboro catchment area to which families and children can receive support as diversions and safe alternatives to 24-hour care. The MCI clinician will work in partnership with family partners to engage the whole family, complete a thorough bio-psychosocial assessment that includes family preferences, resources and natural supports, and work in partnership with the family to determine the next steps for supportive services. The CCBC MCI will have the capacity to support the family throughout the crisis, up to seven days of mobile crisis intervention as needed by the family to stabilize the presenting crisis and facilitate a smooth transition to other CBHI services as needed.

All staff will be capable of providing MCI in community settings throughout the Taunton/Attleboro catchment area.

The MCI staff will have access to two board-certified child psychiatrists, Diane Press, M.D. and Gabriella Velcea, M.D. to discuss clinical dispositions and to resolve complex clinical issues, especially as they arise with children in DCF or DYS custody. The goal of the intervention is to assure the safety and comprehensive clinical management of children in crisis.

A key component of MCI is the initial and ongoing support for the family, provided by both the ESP clinician and the family partner. Families will receive ongoing support as the disposition

is being implemented. The team approach can be especially valuable when families are waiting in the Hospital Emergency Department where the atmosphere can be chaotic and stressful.

CCBC recognizes that the resolution of the presenting problem is only one part of the full crisis intervention. The Wraparound approach includes assistance to the family in identifying natural community supports and resources to give the family additional strengths to support the child in crisis. The support for the child and family also includes a seamless transition to other CBHI services on a timely basis.

3.5.4.2 The CCBC MCI program manager will have a full complement of full-time, part-time and on-call clinical and family partner staff for the Taunton/Attleboro ESP. In addition, there will be a Centralized Triage and clinician assignment capacity that will afford the Taunton/Attleboro MCI program additional resources from the Brockton catchment area to address fluctuating demand in the Taunton/Attleboro area. CCBC can draw upon the current roster of MCI staff that are contracted with DMH as well as the family partners who work in CCBC's CBHI programs. CCBC also has a full complement of outpatient clinicians who are child-trained.

In addition, CCBC will train all ESP clinicians to be competent in completing child clinical evaluations. The additional capacity will help CCBC to address fluctuating demand for children's evaluations. CCBC has had success with hiring parents of children with SED as family partners once the parent has completed their involvement with the CSA.

3.5.4.3 CCBC has learned from our experience in the Wraparound Model of care that the needs of children with SED can vary from hour to hour and day to day. The Wraparound Model provides a foundation to work with the family to assess their needs, mobilize their strengths and provide ongoing support as needed during the crisis. Such an approach will be smoothly adapted to the MCI model of intervention with families up to seven days as needed.

There are several steps to take during the initial intervention to assure access to the seven-day intervention. First the MCI clinician will assess the child's safety and mental status to insure that the symptoms of the serious emotional disturbance can be managed in a home setting. This assessment will be reviewed with the clinical supervisor, ESP program director or consulting child psychiatrist. Second, the family partner will orient the caretaker to the nature of the MCI visit and outline options for them that include placement outside the home, referral to community-based services and ongoing support from the MCI Team that includes both clinical staff and family partners to help stabilize the child. Third, when the clinical assessment is completed, the MCI Team will work with the caretaker to outline the options and help the caretaker to choose the best option, up to and including a seven-day intervention. Finally, the MCI Team will work with the child and family to identify the follow-up services needed post stabilization and identify the steps the family needs to take to secure those resources.

During this time, CCBC will engage other CBHI providers including In-Home Therapy as a transition from the crisis intervention episode to ongoing treatment. The culture in CCBC's CBHI service array involves ongoing flexibility to meet family needs and recognition of the non-linear nature of serious emotional disturbance and family resiliency in crisis.

If CBHI services are already in place for the family, MCI can be accessed to meet additional needs identified in the mobile crisis intervention that fall outside the hours that the CSA and In-Home Therapy are being provided. CCBC has a demonstrated track record to meeting access standards for CSA's without a waiting list. This practice will be extended to the operation of the MCI's ongoing reporting to CCBC's senior leadership.

During the course of the intervention the MCI Team will review the child and family's status with CCBC's ESP clinical leadership to ensure that client safety is being maintained and that progress is being made to stability and follow-up supports.

3.5.5 CCBC has established a culture of linkage to CBHI services through its experience convening Systems of Care meetings in the Taunton/Attleboro catchment area. In Taunton/Attleboro, CCBC MCI staff will meet weekly, or more often if necessary, with CSA and In-Home Therapy program directors to review all children served by the MCI to assess potential referrals. The CCBC MCI will also convene smaller meetings of CBHI providers and other stakeholders to develop safety plans for children at risk of, or following a crisis intervention. CCBC will utilize these linkages to enhance family voice and choice in the establishment of these safety plans that are designed to keep the child at home, support the family, and engage them in the supportive care of their child.

Our CSA has already established working relationships with residential programs operated by DCF, DYS, BSAS, and DMH in the Taunton/Attleboro catchment area. The CSA Program Director has a working relationship with the DCF Area Office that oversees both the Taunton/Attleboro and Brockton areas.

Another strategy to ensure linkages with other CBHI providers is to enlist the support of the Managed Care Entities who can help the MCI staff access CBHI service providers, outpatient providers, and specialty providers to support the family. CCBC recognizes the MCE responsibility to ensure timely access for their members, especially members who are in crisis.

3.6 Runaway Assistance Program (RAP)

CCBC is the designated Runaway Assistance Program (RAP) for the four state-operated Emergency Services Teams in the Southeast Region, as one component of its Emergency Services contract with DMH. This service provides assistance to police officers who are dealing with runaways during the hours the juvenile courts in the Southeast region of DCF are closed. The service operates Monday thru Friday 4:30pm to 8:30am and weekends from Friday 4:30pm thru Monday 8:30am, the times that the courts are not open to respond to these situations. CCBC on-call staff are prepared to respond to conduct a face-to-face assessment of any child age 17 and under who is brought to the ESP community site within one hour of notification.

3.6.1. Describe your experience in collaborating with local police departments, court clinics and DCF relative to youth served by your agency.

CCBC has a long history of collaboration with local police departments, court clinics, and DCF youth. CCBC has provided oversight to the Community Crisis Intervention Team's training program through a contract with the Taunton Police Department. When a CSA or IHT client is involved or potentially involved with the police, the staff will request that the police assign an officer who has been through the CCIT program to provide a more sensitive approach to the child and family. CCBC has also shared crisis safety plans with the police to prevent escalation of crisis situations when law enforcement is involved. The police are invited to the CCBC Systems of Care meetings in the Taunton/Attleboro area. The CCBC CSA Systems of Care has regular collaboration and attendance from the court clinics, DYS, DMH, DCF and Juvenile Justice partners.

CCBC has been designated as the first CSA to participate in the Juvenile Justice Diversion Program in Bristol County, set to begin in the fall of 2015. Court Clinic personnel are invited to attend the Systems of Care meetings hosted by the CCBC CSA.

As stated above, CCBC serves on DCF's Advisory Committee for the Taunton/Attleboro catchment area and invites DCF personnel to attend the monthly CSA Systems of Care meeting.

4. Additional response requirements, if applicable to bidder (considered but not scored)

4.1 Hospitals as bidders

4.1.1 N/A

4.2 Bidders submitting responses for multiple catchment areas

4.2.1 Community Counseling of Bristol County is pleased to submit a proposal for a regional approach covering both the Taunton/Attleboro and Brockton catchment areas to operate the Emergency Services Program for MBHP. We believe that this model offers superior value to clients, their families, MBHP, and the important stakeholders through the creation of an ESP serving a larger region, which provides a more efficient, flexible, effective, uniform, and integrated ESP of the highest quality.

The regional ESP system will be overseen by a program manager who will supervise both the Brockton ESP program director and the Taunton/Attleboro ESP program director. The two combined ESP sites will also benefit from the expertise of a medical director who has been associated with the two ESPs for 5 years. One psychiatrist will be on-call for both sites, substantially reducing the cost of on-call psychiatry. The expanded roster of ESP staff will be available in both catchment areas through CCBC's Centralized Triage, providing greater flexibility to respond to fluctuations in demand. The regional staffing will include a large enough pool of workers for CCBC to recruit specialist staff for the following populations: Hispanics, Cape Verdeans, and persons with developmental disabilities. In addition this model will allow for a team of certified peer specialists and family partners to become integrated into the ESP model and offer greater support to one another. Similarly, continuous quality improvement, risk management and billing functions and cost would be spread over a longer base, reducing total cost.

4.2.2. As the operator of two ESPs in the Southeast region, CCBC will bring a number of strengths that will enhance the goals of the ESP in both operations and in better matching services to the needs of the members. First, CCBC will be able to extend the culture of community-based recovery and collaboration with other stakeholders to ESP services. Second, CCBC will have a wider pool of ESP clinicians, peer specialists, and family partners to draw upon for the Taunton/Attleboro catchment area. As the largest behavioral health provider in the Taunton area, CCBC has refined the skill at recruitment and retention of both clinicians and non-clinical staff. Third, CCBC's community orientation towards strength-based, solution-focused, and client-centered interventions will reduce the volume of clients going to EDs in both areas and will utilize untapped community resources for clients to access to prevent exacerbation of the mental health conditions. Finally, the administrative efficiencies and reduced on-call psychiatric costs will reduce overall costs.

While CCBC believes certain efficiencies are achieved with an ESP serving the combined Taunton/Attleboro and Brockton areas, this proposal is not contingent upon a combined service area. This proposal for the Taunton/Attleboro ESP may be considered a stand-alone proposal.

Community Counseling of Bristol County, Inc.

Policy and Procedure

Title: **Quality Management Plan** Policy Number: VII-01

Effective Date: August 5, 2005

Page: 1 of 7

Reviewed/Revised Dates:

8/2/05, 2/20/14, 5/19/14, 2/10/15, 3/3/15, 3/10/15, 3/18/15, 4/2/15, 6/2/15, 8/26/15

GOVERNANCE AND STRUCTURE

STATEMENT OF POLICY:

In order to fulfill the mission of the Agency, Community Counseling of Bristol County, Inc. is committed to a comprehensive quality management, which includes continuous quality improvement and regular program evaluation.

The purpose of this plan is to ensure that reliable and valid data are gathered, reviewed, analyzed, and utilized in correcting problems, enhancing the quality of the Agency's services, and obtaining and properly managing the human, financial, physical, and community resources, so that the services provided to individuals and families served meets the highest standards of ethics, quality, and cost effectiveness. All services and administrative operations of the Agency are included.

The Agency's Quality Management processes include data collection, review, and management actions that are sufficiently frequent for timely corrections or improvements. The processes are inclusive, involving individuals served, staff, and community and Board representatives. The processes are functionally integrated in ongoing management activities – identifying strengths, weaknesses, and areas for development, and tracking the implementation and success of management actions designed to improve program outcomes, solve problems, and enhance the quality of services.

Quality management includes three essential components. The first, and most important, is an organizational commitment to quality care and to the continuous improvement of that care. Beyond this commitment, the two additional essential components, organizational structures and processes, are required to continuously monitor, measure, and evaluate the care provided. The following describes the organizational structures and processes in place at Community Counseling of Bristol County, Inc. (CCBC) designed to carry out the quality management with respect to the Agency's management and programmatic performance.

1. **CCBC has a governing body, which functions with overall responsibility for the Agency's operations.**

CCBC's Board of Directors is the governing body for the Agency, with overall responsibility for the Agency's operation. The Board meets on a bi-monthly basis. Committees of the Board, Finance Committee, meet monthly or with greater frequency as needed. CCBC's President has regular contact with the Chair of the Board of Directors to update him on Agency services, finances, personnel and related issues. The Agency's President is an ex-officio, non-voting member of the Board of Directors attending all meetings of

the Board of Directors. Other management staff attends meetings of the Board of Directors as requested. At each meeting of the Board of Directors, the President reports to the Board on the organization's finances, services, human resources, regulatory issues and other matters of importance to the Corporation.

At least one member of the Board of Directors participates as a member of the Patient Care Assessment Committee (PCA) and reports to the Board on a quarterly basis. The Patient Care Assessment Committee is a primary mechanism by which the Board of Directors monitors and evaluates the services of the organization. The Agency's PCA Plan is approved by the Massachusetts Board of Registration in Medicine The PCA Committee is comprised of the Chief Operations Officer, the Medical Director, the Vice President of Integrated Care, the Vice President of Adult Outpatient Services, the Vice President of, Child & Family Services, the Vice President of Community Treatment and Rehabilitation, the Vice President of Housing and Special Initiatives, Quality Management and Compliance Coordinator, and other staff as assigned.

The PCA Committee regularly reviews the activities of the Risk Management Committee (RMC), the Safety Committee, and the Human Rights Committee. The Committee also reviews the results of any and all external reviews, including: all investigations, contract performance reviews, compliance reviews and licensing reviews. The Committee also reviews the results of any internal audits and regularly reviews client outcome data and client satisfaction surveys.

The Agency maintains an ongoing program to assure that processes are in place to assess and maintain compliance with regulatory requirements and contractual obligations provides mechanisms for staff reporting and regularly performs tests of compliance in areas identified as critical or difficult from a regulatory compliance perspective or when prior compliance has been a problem.

2. CCBC maintains up-to-date written descriptions of the administrative structure and lines of authority of the Agency.

CCBC maintains an up to date Table of Organization. The Board of Directors is the appointing authority for the positions of President and Medical Director. The President appoints all other staff. The organizational chart is reviewed at a minimum of once a year, but also at each occasion as a new program or service is added to the Agency's continuum of care.

The Leadership Team for the Agency meets on a weekly basis, and is comprised of the President, the Chief Financial Officer, Chief Operating Officer, Vice President of Adult Outpatient Services, Vice President of Child and Family Services, Vice President of Community Treatment and Rehabilitation Vice President of Integrated Care, Vice President of Housing and Special Initiatives, Facilities Manager, and Human Resources Coordinator. Other management staff, including Program Directors, meets with the Leadership Team on a monthly basis. The purpose of this meeting is to assure good communication, disseminate information, and develop and review organizational policies and procedures. Program Coordinators and others are invited for specific projects and discussions. Minutes are kept of each meeting. The Leadership Team is charged with responsibility for all aspects of management of the Agency, including, but not limited to developing and monitoring program budgets, meeting licensing requirements, human resource management, identifying operational problems and solutions, reviewing consumer access and service issues and participating in quality management activities.

3. Assessment of Program Quality and Performance.

The Quality Management Plan is designed to insure that sufficient monitoring and evaluation procedures are in place to assess program quality, measure program performance against stated goals and improve client outcomes and overall program quality.

Components of the Quality Management Plan include:

1. **Standards and Performance Evaluation:**

   (a) Evidence Based and Evidence Informed Practices: The organization is committed to meeting or exceeding the expectations of our stakeholders. Stakeholders include clients, purchasers, staff, regulatory agents, and community members. Meeting or exceeding the expectation of stakeholders is closely associated with providing care and treatment based upon the best science and treatment approaches available. In behavioral health care the best science available is incorporated into what is known as evidenced-based or evidence informed practices. Whenever possible the organization embraces evidenced based practices in the delivery of care and treatment. Current evidence based practices include Dialectical Behavior Therapy in Day Treatment and CBFS, Motivational Interviewing in Outpatient, and Illness Management and Recovery (IMR) in Day Treatment and CBFS. The PACT and CSA programs are also held to tight industry fidelity standards.

   (b) Client Outcome Data: On no less than an annual basis, all programs establish appropriate methods for assessing and measuring client outcomes both on a client specific basis and on an overall program basis. These data will serve as a critical component of program evaluation and the basis for initiatives to improve client outcomes.

   (c) Risk Management Data: All agency incidents, as described later in this document, are recorded, categorized and aggregated in order to analyze trends and inform performance improvement.

   (d) Continuous Quality Improvement: Each year opportunities for quality improvement are identified. With input from its constituencies, objectives are set for major programs. Each program also identifies responsible parties, resources, processes, and timetables needed for implementing the plan. In establishing goals and objectives for quality improvement, the Agency obtains input from, and considers the interests of clients and their families, referral and funding sources, other community representatives, staff, and the governing body.

   Objectives are generally derived from the following categories:

   1. **Service outcomes, indicating effectiveness and/or cost-effectiveness of services. Examples: independence, as measured by decreases in required personal assistance and supervision for clients living in group living environment.**

   2. **Service progress, indicating the progress of clients served in their course of program activities. Examples: the percentage of individual service plan objectives achieved vs. set for clients with severe and persistent mental illness.**

   3. **Service processes, indicating the amounts, utilization, timeliness, appropriateness, and quality of services, and their documentation, as measured by routine service and/or management data systems, and by special audit processes. Special systems to monitor the protection of client rights and client choice are also measured. Examples; the average time between referral and evaluation by a prescribing clinician; the percent of individual service plans updated as specified by timeliness standards; the number of serious human rights complaints filed in a given time period.**

4. **Management of human, financial, physical, and community resources. Examples: the percentage of staff turnover in a given time period; the average time required to complete a repair or maintenance task.**

5. **Stakeholder surveys for all areas of operation, including service outcomes, progress, and processes, and surveys of staff, referral source, funder, and customer/community satisfaction with program services and management. Example: customer satisfaction ratings on several dimensions of access, service, and outcome.**

6. **Client Satisfaction Surveys are conducted regularly in all programs providing an important information and direction from agency clients regarding the appropriateness and effectiveness of the programs and services and ideas on how to improve the quality of the service.**

(e) A common approach for guiding quality efforts is the *PDCA* Model, referring to the stages of *Plan, Do, Check, Act* as described below.

Plan: **Identify the area of focus, process, or element that will be concentrated upon. Having past data will be important here for more longitudinal efforts. Develop measurement standards, quality measures to be employed, and indicators used in the *Do* stage. Current baseline data will be required for comparison in the *Check* stage.**

Do: **Implement the designs created in the *Plan* stage. Collect data as designed.**

Check: **Examine the data collected. Assess the data's accuracy, validity, and reliability. Is the information meaningful and informative? Was the goal(s) achieved? From a PDCA stand point, what worked well and what could be improved upon for future cycles?**

Act: **Take action on the information. Make adjustments for future planning. Start the *PDCA* cycle over again.**

2. <u>Human Resource Management</u>

(a) <u>Credentialing and Privileging</u>: A system of credentialing and privileging for staff licensed at the independent level is in place and is reviewed and updated by the Professional Services Review Committee (PSRC). The PSRC is comprised of the President, Chief Operating Officer, Medical Director, and Vice Presidents. Credentialing includes verification of academic degrees, licensure, and previous employment experience. References are required and documented. Staff are privileged by the Board of Directors subsequent to credentialing and review by the PSRC.

(b) <u>Training</u>: <u>All clinical and direct care staff positions will have an identified set of core competencies described as part of the job description. The job description will also indicate how the core competencies are to be evaluated. In most instances, there will be a specific set of training requirements which must be complete in order to satisfy that these core competencies have been evaluated and achieved. Each program manager will be responsible for establishing these training requirements and documenting that they have been fulfilled. All professional</u>

licenses are updated periodically, generally every two years. All licensed staff is required to have a current license on file with the Human Resources office.

(c) **Supervision**: All direct care and clinical staff will receive regular supervision. Individual clinical supervision for staff providing outpatient services occurs on a regularly scheduled basis in accordance with Department of Public Health regulations. Clinical supervision is documented by the supervisor. The focus of supervision is to review the quality and clinical appropriateness of care.

(d) **Staff Evaluation**: Newly hired employees will receive an evaluation at the end of three months. This review will be documented. Subsequent to the first three months of employment, employee evaluations will be conducted each year. Staff who exhibit performance difficulties, may receive an evaluation and/or performance improvement plan at any time during his/her employment. New staff may be evaluated prior to their one year anniversary. Also, any staff person who is on some disciplinary status will have an evaluation at a timeline indicated in the written notice.

(e) **Continuing Education**: The Agency has **an organized training initiative** in which managers, supervisors and line staff from the continuum of services participates. The Agency offers a staff training and education program that focuses upon incorporating evidenced-based practices into the Agency's practices at all levels. Managers and supervisors review the professional literature to identify evidenced based practices and to design relevant training curriculum, which is required of CCBC employees.

(f) CCBC has an online learning system that has the capacity to support, advance, and track agency and programmatic training initiatives. The system includes over 600 offerings and can be used to create program-specific courses and individual specific curricula.

(g) The Agency offers **staff training opportunities** to access workshops offered outside CCBC. When resources permit, financial assistance towards the cost of the workshop is provided.

All staff are expected to maintain any and all relevant licenses for which they are eligible and secure all necessary continuing education credits to do so.

3. **Risk Management and Safety**

(a) **Risk Management Committee** was developed to address the needs of CCBC consumers, staff and the community at large with respect to insuring the operation of the Agency's program in a manner that promotes the safety, well-being and dignity. This Committee is chaired by the President and includes the Vice President of Adult Outpatient Services, Chief Operations Officer, the Vice President of Community Rehabilitation Services Vice President of Community Treatment and Rehabilitation, Vice President of Housing and Special Initiatives, Medical Director, Vice President of Integrated Care, the Vice President of Child and Family Services, and the Quality Management and Compliance Coordinator..

The responsibility of the Risk Management Committee is to provide timely and ongoing review of those incidents, events and situations that present the potential for significant risk to the safety or wellbeing of clients, staff or others and to make recommendations as to clinical, supervisory and administrative procedures and protocols to the governing body, Patient Care Assessment Committee, Leadership Committee, and other committees as appropriate. A file of all incidents

is maintained. All incidents are reviewed and action taken as appropriate. All action taken by the Committee is documented in writing.

The Risk Management Committee reviews the following:

Major Incidents As Defined By the Board of Registration in Medicine 243 CMR 3.08:

1. Maternal deaths that are related to delivery.
2. Death in the course of, or resulting from, elective ambulatory procedures.
3. Any invasive diagnostic procedure or surgical intervention performed on the wrong organ, extremity or body part.
4. All deaths or major or permanent impairments of bodily functions (other than those reported above) that are not ordinarily expected as a result of the patient's condition on presentation).

Critical Incidents: With respect to all clients deemed eligible and receiving services under contract between CCBC and the Department of Mental Health, any events defined as a Critical Incident by DMH Critical Incident Reporting Protocol effective October 1, 2012 and any subsequent reviews.

Serious Incidents (Department Of Public Health):
Serious Incidents as defined by the Department of Public Health (105 CMR 140.307) which includes any of the following which occur **on the Agency's premises**:

1. Fire,
2. Suicide,
3. Serious criminal acts; or
4. Pending or actual strike action by employees.

Risk Management Screening and Monitoring Events:
Such other events and situations determined by the **CCBC RISK COMMITTEE** not limited to but including:

1. Any situation which a supervisor or a clinician requests a risk assessment or review.
2. All client deaths including, but not restricted to, medical/legal deaths.
3. All incidents of any suicide attempt that results in medical treatment or results in significant injury, or could have resulted in significant injury or impairment.
4. All requests for commitment under the provision of Section 12E of M-G-L CH 123, issued by any member of our clinical staff (psychiatrists, psychologists and clinical nurse specialists).
5. Any alleged sexual assault by a client or upon a client at any agency facility.
6. Any injury to a client or to a staff member at an Agency facility.
7. Any injury to a staff member while on duty.
8. Any violence by a client directed toward another client or staff. This includes threats and acts of intimidation.
9. Situation which gives rise to a "duty to warn" third parties of the likelihood or threat of aggression by a client or if a client utters any threat to staff, clients or others.
10. Any mandated reporting required of providers under Massachusetts General Laws pertaining to the neglect of children (51A), the abuse or neglect of disabled persons per the Disabled Person's Protection Commission, or the abuse or neglect of elderly persons.
11. Any reported or alleged human rights complaint.

12. Any written complaint filed by a client, parent or guardian of a client with regard to their care or the care of their child for whom they have custody, or the individual for whom they are guardian, or ay complaint that the Committee chooses to review.
13. Any medication occurrence.
14. Any act of violence against a staff member of the agency, including assault, assault and battery, threats, intimidation or coercion that occurs during the course of their service.
15. Any act of violence against a client of the agency in the course of their receiving care provided by the agency.

1. **Safety Committee**: The organization maintains a Safety Committee for the purpose of ensuring that services are provided in a manner that promotes safety for clients, staff, and the community. The Safety Committee reviews its activities with the Board of Directors on a regular basis and makes recommendations to the Board and management with respect to the safety of clients and staff. The Safety Committee reviews the Workplace Violence Prevention Plan at least annually and makes recommendations to management as to changes in the Plan.

2. **Human Rights and Consumer Involvement**

(a) Human Rights Committee: CCBC has a Human Right Committee with several agency clients serving on the Committee. The Organization's Human Rights Officer attends committee meetings and serves as liaison between the Committee and the Management Team, and the governing Board. The Human Rights Committee follows DMH guidelines 104 CMR 15.03(13) (a-f) and 15.03(5) (I) for Community Programs.

The responsibilities of the Committee include, but are not limited to:

- Review of Human Rights complaints.
- Review proposed Agency policies, which may have an impact on human rights.
- Review and monitor any research projects of the Agency which involve consumers.
- Annual visits and inspections of Agency sites, with recommendations reported to the Management Team.

(b) Consumer Involvement includes a variety of activities to facilitate consumer participation in the development and review of their service plan and in the review and evaluation of the Agency's programs and services.

These processes include:

- A commitment to person-centered care and treatment where the consumers' needs and preferences are incorporated into all aspects of the service plan.
- Inclusion of those with lived experience in all of the organization's major programs. Those with lived experience play a critical role in ensuring that programs and services are person-centered and sensitive to the needs, preferences and goals of those receiving care. Those with lived experience bring a particular sensitivity to the attitudes, processes and approaches that facilitate a recovery oriented treatment system. Those with lived experience can also serve as role models for those in early stages of recovery and can serve to illustrate that recovery is possible and achievable;
- Program specific satisfaction surveys that gather data with respect to consumer perception of service delivery.

2.3.2.1 Specific plan on how our organization shall collaborate with hospital to achieve goals related to ED diversion and ensure timely response

2.3.2 ED-specific plans related to ED diversion and timely response.

2.3.2.1 Hospital Diversion Plans

2.3.2.1.1 Please describe how you shall work with Brockton Hospital Emergency Department in an ongoing, collaborative and integrated fashion.

CCBC will establish a working relationship with the **Brockton Hospital ED** at a number of levels:

CCBC Contact	Hospital ED Contact	Scope of Collaboration
CEO	CEO	Negotiate Memorandum of Understanding
ESP Medical Director	ED Medical Director	Establish working protocols on medical and psychiatric issues and develop criteria on level of care for inpatient, CCS, and community alternatives. Act as final arbiters of clinical presentations and dispositions; approval of clinical policies on ESP activity. Participate in monthly community stakeholder meetings.
Psychiatrist On- Call	ED Physician	CCBC psychiatrist provides consultation on acute cases, including recommendations for psychopharmacology to stabilize acute patients who have experienced extended stays in the ED.
ESP Program Director	ED Nurse Manager	Review monthly statistics; identify cases for monthly review; resolve logistical issues on timeliness and ESP staffing; ensure ongoing communication during ED back-ups; implement MOU.

CCBC will assign one ESP clinician to the Brockton Hospital Emergency Department. They will be available to provide mobile crisis interventions at the hospital ED from 4 p.m. to midnight Monday through Friday. Additional staff can be deployed from the Brockton Community Based Location on weekends.

The CCBC clinician will work closely with the triage nurse and the ED physician in charge to provide timely assessments and joint treatment planning. The ESP clinician will have access to a telephone.

The ESP program director will schedule regular meetings every other month to discuss the working arrangement. The goal is to improve communication, validate response times, assure CCBC accountability to ED staff, and resolve any hospital issues with the appropriate ED managers. The ESP program director and the ESP medical director will attend the meeting. **With a regional approach in mind, CCBC's ESP will combine these meetings with the regular meetings conducted with Good Samaritan Hospital. This arrangement will result in more efficient dissemination of information on methods of reducing utilization of both ED's.**

2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served and the community serviced by that hospital--for how you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP's alternative community-based settings and services.

The population served by the Brockton Hospital ED represents the diverse cultures of the city of Taunton with a higher concentration of Medicaid and uninsured than the demographics, including a higher concentration of Portuguese-speaking clients, including children. The CCBC ESP will be able to meet the needs of these clients based on its successful staffing and support for existing CCBC programs in the Brockton catchment area. In addition to recruiting bilingual/bicultural front office staff, CCBC will actively recruit clinicians who speak Portuguese, Spanish and other languages.

CCBC will deploy three strategies to divert behavioral health clients from the ED:

- First, CCBC will work in the community with referral sources about the increased mobile capacity of the ESP and the availability of peer specialists and family partners.

- Second, CCBC and the ED staff will conduct a survey of ED clients who present for behavioral health assessment. The survey will ask whether the client or referral sources called CCBC before, whether they considered a mobile visit or a visit to the ESP community site before coming to the ER, and whether their health care provider had counseled them about alternatives to the ED. CCBC will use the results of this survey to identify the best target for follow-up information and social marketing in the community.

- Third, CCBC will work with ED staff to triage follow-up in the community-based location in Brockton and, if necessary, the CCBC clinic site in Taunton, to try to minimize the pattern of clients returning to the ED by habit, even in non-crisis situations.

CCBC will set up meetings with the ED administrators at Brockton Hospital to identify cohorts, or sub-populations familiar to them who may be considered "convenience" users of ED services. The ESP will follow up with these providers who are identified from these cohorts to develop alternative response plans, informing them that the CCBC Triage and Mobile Crisis Intervention are viable alternatives to the ED as first point of contact.

CCBC will also have a standing offer from the ESP medical director to the ED program director to convene an ad hoc meeting when a complex presentation cannot be immediately resolved. The ESP will take the responsibility to convene interested parties, including the Managed Care Entity, state agencies who are involved with the client, primary care providers, and other behavioral health providers.

2.3.2.1.3 Describe how you will minimize the need for ED "boarding" and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.

CCBC recognizes that ED boarding is a serious problem across the Commonwealth. Both Brockton and Good Samaritan Hospitals have had unusual spikes in volume that can precipitate ED Boarding for days. There are several ways to minimize the spikes and to quickly address the high volume cases:

- CCBC will establish an electronic method of developing and storing Safety Plans, Crisis Plans, and other upstream plans that can provide structured interventions before clients at high risk are referred to the ED.

- CCBC's ESP psychiatrists will also be available 24/7 to consult with the treating ED physician on appropriate medication regimens for clients with extended stays in the ED and for clients who are highly agitated and at acute risk of harm to self or others. Some of these interventions are likely to stabilize clients and enable referrals to CCS as a diversion from inpatient hospitalization, thus reducing the volume in the EDs.

- The ESP staff can track bed availability using the MABHS "Bedfinder" to alert staff, ED managers, and community stakeholders of limited availability and prioritize timely hospitalizations.

- ESP and ED staff will develop criteria to flag complex cases, such as adults with histories of violence, children and adolescents with SED and Autism or PDD, and adolescents with recent histories of violence. When the clinician completes an assessment with this type of presentation, the ESP director will inform the MCE immediately to request assistance with placement and plan to convene the appropriate community stakeholders to plan for disposition.

2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. What volume do you anticipate initially, and what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis?

CCBC will monitor compliance within the timeframes based on a daily review of the ESP case records from the previous day by the ESP program director and a monthly review of aggregated data by the ESP Director and the hospital ED staff. This information will be discussed at the regular meetings. Real time accountability will be assured by the availability by pager of all CCBC-ESP supervisory and managerial personnel, up to and including the ESP program director.

CCBC estimates that there will be about 116 requests for crisis intervention each month in the Brockton ED. When the demand for ESP evaluations creates delays in timely access in the ED, CCBC will provide additional back-up from the "all-around" clinician available through the Lynn Community-Based Location, who can be dispatched by the Triage staff. CCBC expects to reduce that amount to 100 per month in the FY 2017.

A contract with Brockton Hospital will be signed before January 1, 2016.

2.3.2 ED-specific plans related to ED diversion and timely response.

2.3.2.1 Hospital Diversion Plans

2.3.2.1.1 Please describe how you shall work with Good Samaritan Hospital Emergency Department in an ongoing, collaborative and integrated fashion.

CCBC will establish a working relationship with **Good Samaritan Hospital ED** at a number of levels:

CCBC Contact	Hospital ED Contact	Scope of Collaboration
CEO	CEO	Negotiate Memorandum of Understanding
ESP Medical Director	ED Medical Director	Establish working protocols on medical and psychiatric issues and develop criteria on level of care for inpatient, CCS and community alternatives. Act as final arbiters of clinical presentations and dispositions; approval of clinical policies on ESP activity. Participate in monthly community stakeholder meetings.
Psychiatrist On- Call	ED Physician	CCBC psychiatrist provides consultation on acute cases, including recommendations for psychopharmacology to stabilize acute patients who have experienced extended stays in the ED.
ESP Program Director	ED Nurse Manager	Review monthly statistics; identify cases for monthly review; resolve logistical issues on timeliness and ESP staffing; ensure ongoing communication during ED back- ups; implement MOU.

CCBC will assign one ESP clinician to the Good Samaritan Hospital Emergency Department. They will be available to be on site from 4 p.m. to midnight five days per week. The CCBC clinician will work closely with the triage nurse and the ED physician in charge to provide timely assessments and joint treatment planning. The ESP clinician will have access to a telephone in the ED.

The ESP program director and the ESP medical director will schedule monthly meetings at the outset to discuss the working arrangement. The goal is to improve communication, validate response times, assure CCBC accountability to ED staff, and resolve any hospital issues with the appropriate ED managers.

2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served by that hospital, and the community serviced by that hospital--for how you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP's alternative community-based settings and services.

The clients served by the Good Samaritan ED represent the demographics of the surrounding communities in the Brockton catchment area. In addition, clients from local DMH group living environments (GLEs) and nursing homes also present at the Good Samaritan ED.

CCBC's ESP clinicians have the skills and experience to conduct thorough crisis interventions with clients from these populations.

CCBC will deploy three strategies to divert behavioral health clients from the ED:

- First, CCBC will work in the community with referral sources about the increased mobile capacity of the ESP and the availability of peer specialists and family partners.

- Second, CCBC and the Good Samaritan ED staff will conduct a survey of ED clients who present for behavioral health assessments. The survey will ask whether the client or referral sources called CCBC before, whether they considered a mobile visit or a visit to the ESP community site before coming to the ER, and whether their health care provider had counseled them about alternatives to the ED. CCBC will use the results of this survey to identify the best target for follow up information and social marketing in the community.

- Third, CCBC will work with ED staff to triage follow up in the community-based location in Brockton for urgent psychopharmacology and at nearby clinic sites in the area to minimize the pattern of clients returning to the ED by habit even in non-crisis situations.

CCBC will have meetings at Good Samaritan Hospital where the ED administrators identify cohorts, or sub-populations familiar to them who may be considered "convenience" users of ED services. The ESP will follow up with providers identified in the Good Samaritan survey to develop alternative response plans, informing them that the CCBC Triage and Mobile Crisis Intervention are viable alternatives to the ED as first point of contact.

CCBC will also have a standing offer from the ESP Medical Director to the ED Director to convene an ad hoc meeting when a complex presentation cannot be immediately resolved. The ESP will take the responsibility to convene interested parties, including the Managed Care Entity, state agencies who are involved with the member, primary care providers, and other behavioral health providers.

2.3.2.1.3 Describe how you will minimize the need for ED "boarding" and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.

CCBC recognizes that ED boarding is a serious problem across the Commonwealth. Both Brockton and Good Samaritan Hospitals have had unusual spikes in volume that can precipitate ED Boarding for days. There are several ways to minimize the spikes and to quickly address the high volume cases:

- CCBC will establish an electronic method of developing and storing Safety Plans, Crisis Plans and other upstream plans that can provide structured interventions before clients at high risk are referred to the ED.

- CCBC's ESP psychiatrist will also be available 24/7 to consult with the treating ED physician on appropriate medication regimens for clients with extended stays in the ED and for clients who are highly agitated and at acute risk of harm to self or others. Some of these interventions are likely to stabilize clients and enable referrals to CCS as a diversion from inpatient hospitalization, thus reducing the volume in the ED's.

- The ESP staff can track bed availability using the MABHS "Bedfinder" to alert staff, ED managers, and community stakeholders of limited availability and prioritize timely hospitalizations.

- ESP and ED staff will develop criteria to flag complex cases, such as adults with histories of violence, children and adolescents with SED and Autism or PDD, and adolescents with recent histories of violence. When the clinician completes an assessment with this type of presentation, the ESP director will inform the MCE immediately to request assistance with placement and plan to convene the appropriate community stakeholders to plans for disposition.

2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. What volume do you anticipate initially, and what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis? Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED?

In addition to the ESP clinician assigned to Good Samaritan Hospital ED on weekday evenings, CCBC will provide back up and triage from the centralized CCBC ESP Team at the Community-Based Location in Norton. Real time accountability will be assured by the availability by pager of all CCBC ESP supervisory and managerial personnel, up to and including the ESP program director. CCBC ESP expects to complete on average about 90 crisis interventions monthly in the Good Samaritan ED, but will reduce it to 80 per month in FY 2017 with creative strategies to increase mobile crisis interventions outside of the ED.

CCBC monitors compliance within the timeframes based on a daily review of the responsiveness from the ESP case records from the previous day and a monthly review of aggregated data by the ESP director and the hospital ED staff. This information is discussed at meetings that are held every month. **The CCBC regional approach will allow for a full-time ESP quality/risk manager to develop, distribute, collect and analyze the response time data, the survey data, and the results of the corrective actions to achieve MBHP goals, and in both the Brockton and Taunton-Attleboro catchment areas.**

The contract with Good Samaritan Hospital will be operational by January 1, 2016.

2.4.3.1 Professional development activities and trainings that our organization has provided staff related to resilience, rehabilitation, and recovery within the last two years

ESP RFR Attachment 2.4.3.1

List of Trainings and Professional Development Activities Related to Resiliency, Rehabilitation and Recovery in the Past Two Years

- 2013 Mass Psychiatric Rehabilitation Association (PRA) Conference: Connections for Life: Recovery and Community Partnerships

- 2014 Mass PRA Conference-Supporting the Recovery Workforce Toward Lifelong Learning

- Training taken on-line by CCBC staff from CCBC's On-Line Training Resource - *Relias*:
  - WRAP (Wellness Recovery and Action Plan) Values and Ethics:
  - Mental Health Recovery and WRAP (Wellness Recovery Action Plan);
  - Intentional Peer Support-A Different Kind of Relationship;
  - Mental Health Recovery and WRAP (Wellness Recovery Action Plan):
  - Key Recovery Concepts;
  - Peer Support: Supporting One Another in Recovery;
  - A Culture-Centered Approach to Recovery.

- "Illness Management and Recovery" - a three day training by the Bridge of Central Massachusetts

  - CCBC staff also participated in an online webinar, "Peers as Crisis Service Providers II" sponsored by SAMHSA

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2.5.2.1.5 Professional development activities and trainings that our organization has provided for staff relative to cultural competence with the last two years

List of Trainings and Professional Development Activities Related to Cultural Competence in the Past Two Years

CCBC utilizes the Relias Training System to provide and track all staff training since September 2014. Training provided in cultural competence is included in the core competency curriculum for many CCBC programs, including Community Based Flexible Support, DBT, and PACT Services.

Training over the past two years included:

- A Culture Centered Approach to Recovery
- Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence
- Cultural Issues in Mental health Treatment
- Cultural Issues in Treatment for Paraprofessionals
- Cultural Diversity

In Person Trainings attended:

- BSAS training on implementing the CLAS Principles
- Military Culture, In-person BSAS training by Ben Cluff
- Mass-PRA Conference-2013: Allies in Recovery: Learning to Engage Racially and Culturally Diverse Adults with Psychiatric Conditions
- Mass-PRA Conference 2014: Courageous Conversations: Unpacking the Construct of Race
- DPH Ounce of Prevention conferences: 2015: Adewale Troutman, MD, who spoke on "Creating a Health Equity Movement."
- NACCHO conference 2015-" Cultivating a Culture of Health Equity"

3.1.9.1.1 – 3.1.9.1.3

Job description of ESP Program Director and Resumes of Quality Management Coordinator and Medical Director

ESP RFR Attachment 3.1.9.1.1

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR):	**102 Program Director**
Position Title:	Program Director
Program Name:	Emergency Services Program
Service Type:	Emergency Services
Accountability:	Vice President of Emergency and Diversionary Services

Summary of Position:

The Program Director (PD) is responsible for the overall operations of the ESP, including the supervision of all ESP staff and the clinical effectiveness of the program. The PD's primary function is to:

- Share responsibility with the ESP Medical Director for the clinical oversight and quality of care across ESP services.
- Responsible for the administrative and financial oversight of the ESP contract.
- Serve as primary point of accountability to MBHP and MCEs for the ESP.
- Ensure compliance with all requirements and performance specifications, including standard assessment tools, electronic encounter forms, and other data collection mechanisms.

Education/Training:

- Master's degree in Social Work or related mental health field or doctoral level.
- Must be independently licensed (LICSW, LMHC, PhD).
- Must have at least five (5) years post-graduate experience providing behavioral health services to children, families, and adults.
- Must have at least three (3) years of supervisory and/or management experience.

Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, potential safety issues, etc.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.

- Must be able to articulate and promote a recovery-orientation that is resolution-focused, strengths-based, and culturally competent.
- Ability to manage resources, including the hiring and retention of culturally competent staff.
- Possess knowledge and practice skills regarding Continuous Quality Improvement (CQI).
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties, as well as the written skills required to manage an electronic health record system.

Responsibilities:

- Administer the recruiting and hiring process for all ESP employees.
- Develop and maintain community connections with key stakeholders
- Develop and maintain programmatic policies and procedures to support a high fidelity ESP.
- Develop and maintain the training process and protocols for all new staff.
- Provide weekly individual and group supervision to staff and conduct regular performance reviews.
- Supervise program staff, which includes providing clinical support and oversight.
- Provide monthly trainings to all program staff to ensure compliance with all agency and managed care entities mandates.
- Oversee and ensure that all managed care entities' performance specifications and medical necessity criteria are being maintained by program.
- Collaborate with community resources, local and state agencies, schools, therapists and vocational programs.
- Facilitate monthly meetings and maintain collaborative partnerships with managed care entities and various states agencies including DMH, MCI and DCF.
- Provide oversight and support to all staff in ensuring they are completing all mandated responsibilities. This includes various quality management tasks and managing any staff disciplinary issues/performance improvement efforts.
- Manages various reports needed within the program to meet Mass Health requirements
- Provides on-going support to all team members as needed.
- Provides clinical oversight to all program matters and cases.
- Assist in the development of fiscal budgets and maintain program operations within allotted budget.

List Other Job Requirements:

All staff must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.

All staff must maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren). All staff must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

Physical Requirements:

All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance. All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

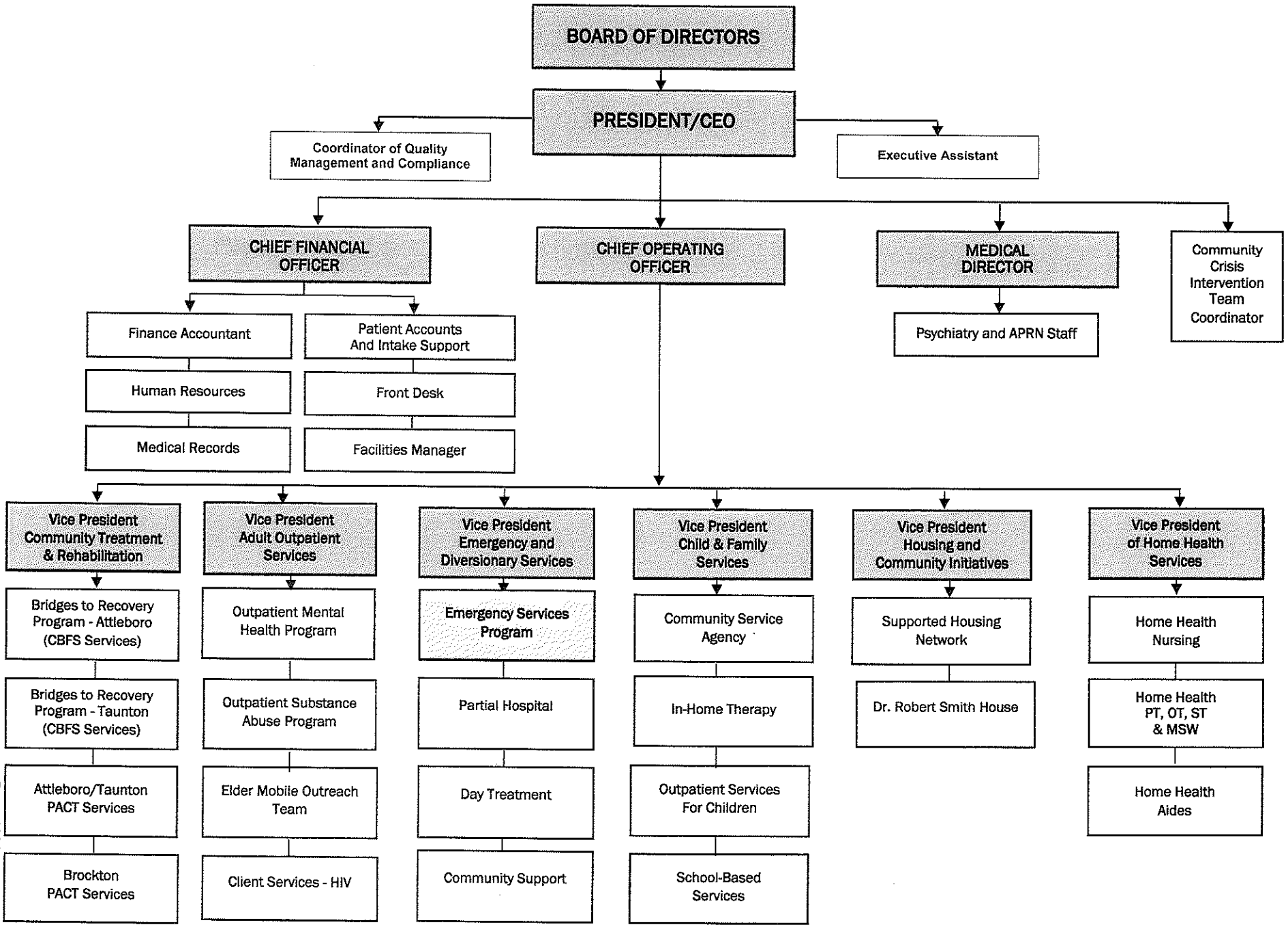
_____ _____

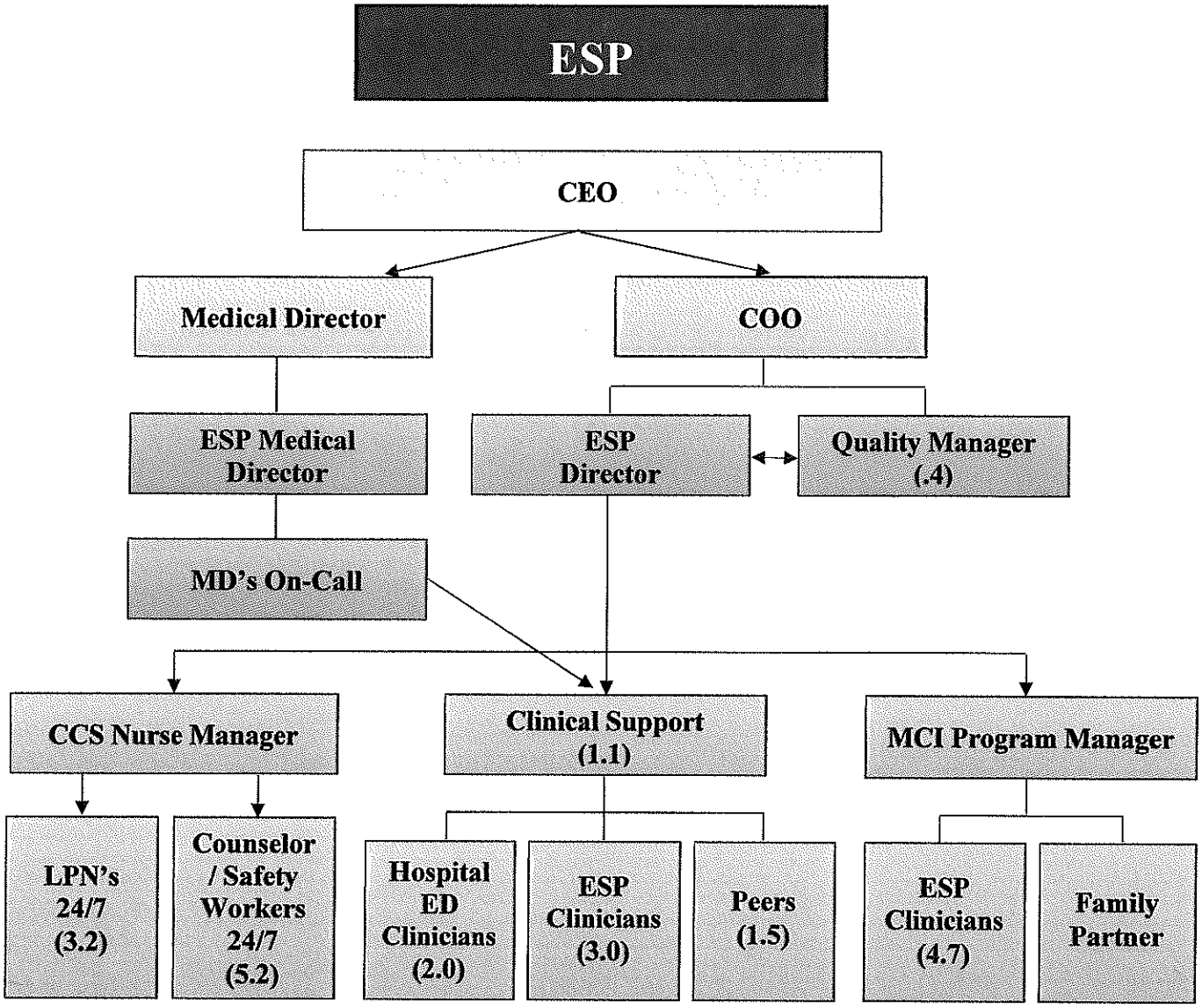
Signature Date

3.1.9.2 Organization chart that indicates where ESP key staff shall sit within the organization at an administrative and supervisory level

Community Counseling of Bristol County, Inc.

TABLE OF ORGANIZATION





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3.5.3.3 – 3.5.3.6

Evidence of competence working in partnership with youth, parents, and caregivers of youth with mental health needs

Policies, procedures, and protocols developed for provision of behavioral health services to youth and families

Outcome data, quality improvement processes and satisfaction survey results focused on youth and families

Training, licensing certification and verification of expertise in providing behavioral health services to youth and families

Family Support Partner—Tier One Certification Checklist

Exercise		Date Verified
1	Pre Reading and Preparation for Training Exercise	
2	Tier One and Tier Two Certification	
3	The Principles of Wraparound	
4	The Phases and Activities	
5	The Theory of Change	
6	Staff Roles	
7	The VVDB Action Steps	
8	Challenges to Engaging Families	
9	Trust Building, Voice and Choice, and Self Efficacy	
10	Develop your own Family Scenario	
11	Behavioral Rehearsal of Engagement	
12	Initial Meeting with the Family (continues)	
13	Crisis Stabilization	
14	Your Personal Natural Supports	
15	Natural Supports in your Scenario Family	
16	Impact and Explaining the SNCD	
17	Life Domains	
18	Learning more about Wraparound & Spirituality Boundaries	
19	Long Range Vision and Prioritized Needs	
20	Family Culture	
21	Practicing the SNCD	
22	Explaining Wraparound to Custodial Agency Staff	
23	Preparing the Family and Team	
24	Recruiting a Reluctant Team Member	
25	Supporting Families towards Independence	
26	Completing the first SNCD	
27	Debriefing the SNCD Assignment	
28	Ensuring that SNCD drift does not occur	
29	Choose the Right Sequence for Planning	
30	Using the DVD family (Mariam) building "AJs plan, add strengths and set ground rules	
31	Adding to the Team Mission	
32	Prioritized Needs	
33	Developing Goals, Objectives and Measurement Strategies	

Exercise		Date Verified
34	Options and Action Steps	
35	The Terms of Functional Assessment	
36	Functional assessment	
37	Crisis plan	
38	Progress Tracking Measures	
39	Needs and Services	
40	Individualization of Transition	
41	Story Board Brainstorming	
42	Team Cohesion: Dealing with Team Fragmentation	
43	Recruitment of Surrogate Supports	
44	Family Culture in Area of Celebration of Milestones	
45	Building Self Efficacy for a Family	

Shadowing Activities		Date Verified
1	a. Observe engaging a family.	
	b. An additional observation of engaging a family.	
2	a. Observe preparing a family for the SNCD.	
	b. An additional observation of preparing a family for the SNCD.	
3	a. Observe a sample of gathering information.	
	b. An additional observation of gathering information.	
4	a. Observe identifying and building natural supports	
	b. An additional observation of identifying and building natural supports	
5	a. Observe preparing a family for a meeting.	
	b. An additional observation of preparing a family for a meeting.	
6	a. Observe recruiting team members.	
	b. An additional observation of recruiting team members.	
7	a. Observe planning meetings.	
	b. An additional observation of planning meetings.	

Supplemental Exercises		Date Verified
1	Layout the roles of Wraparound Staff in agency	
2	Behavioral rehearsal: Engaging families	
3	Behavioral rehearsal: Sharing your experience to prepare for SNCD	
4	Behavioral rehearsal: Gathering information	
5	Behavioral rehearsal: Identifying and building natural supports	
6	Behavioral rehearsal: Preparing a family for the initial WA meeting	
7	Behavioral rehearsal: Recruiting team members	

Coaching Debriefing Comments:

Wraparound Facilitator—Tier One Certification Checklist

Exercise		Date Verified
1	Pre Reading and Preparation for Training Exercise	
2	Tier One and Tier Two Certification	
3	The Principles of Wraparound	
4	The Phases and Activities	
5	The Theory of Change	
6	Staff Roles	
7	The VVDB Action Steps	
8	Challenges to Engaging Families	
9	Trust Building, Voice and Choice, and Self Efficacy	
10	Develop your own Family Scenario	
11	Behavioral Rehearsal of Engagement	
12	Initial Meeting with the Family (continues)	
13	Crisis Stabilization	
14	Your Personal Natural Supports	
15	Natural Supports in your Scenario Family	
16	Impact and Explaining the SNCD	
17	Life Domains	
18	Learning more about Wraparound & Spirituality Boundaries	
19	Long Range Vision and Prioritized Needs	
20	Family Culture	
21	Practicing the SNCD	
22	Explaining Wraparound to Custodial Agency Staff	
23	Preparing the Family and Team	
24	Recruiting a Reluctant Team Member	
25	Supporting Families towards Independence	
26	Completing the first SNCD	
27	Debriefing the SNCD Assignment	
28	Ensuring that SNCD drift does not occur	
29	Choose the Right Sequence for Planning	
30	Using the DVD family (Mariam) building "AJs plan, add strengths and set ground rules	
31	Adding to the Team Mission	
32	Prioritized Needs	

Exercise (Continued)		Date Verified
33	Developing goals, objectives and measurement strategies	
34	Options and action steps	
35	The terms of functional assessment	
36	Functional assessment	
37	Crisis plan	
38	Progress tracking measures	
39	Needs and services	
40	Individualization of transition	
41	Story board brainstorming	
42	Team cohesion: Dealing with team fragmentation	
43	Recruitment of surrogate supports	
44	Family culture in area of celebration of milestones	
45	Building self efficacy for a family	
Shadowing Activities		**Date Verified**
1	a. Engaging families in a meeting	
	b. An additional experience engaging families in a meeting	
2	a. Strengths, Needs, and Culture Discovery with a family	
	b. An additional experience with SNCD	
3	a. Preparing a family for a meeting	
	b. An additional experience preparing a family for a meeting	
4	a. Recruiting team members	
	b. An additional experience recruiting team members	
5	a. First team meeting	
	b. An additional experience of the first team meeting	
6	a. Functional assessments	
	b. An additional experience with functional assessments	
7	a. Crisis team meetings	
	b. An additional experience with crisis team meetings	
Supplemental Exercises		**Date Verified**
1	Layout the roles of Wraparound Staff in agency	
2	Behavioral rehearsal: Engaging families	
3	Behavioral rehearsal: The SNCD	
4	Behavioral rehearsal: Preparing the family for a team meeting	
5	Behavioral rehearsal: The first team meeting	
6	Behavioral rehearsal: Doing a functional assessment	
7	Behavioral rehearsal: Crisis planning meeting	

FY 2014 Annual Member Satisfaction Survey Data Results

Q#	QUESTION	STRONGLY AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NOT ANSWERED	TOTAL RESPONSES
1	Does your care coordinator help you to understand the Community Service Agency and Wraparound?	31	1	0	1	1	0	34
		91%	3%	0%	3%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
2	Is involvement in community-based activities reflected in the care planning process?	23	5	3	0	1	2	34
		68%	15%	9%	0%	3%	6%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	91%						
3	Are there on-going and persistent efforts to engage natural supports?	27	4	1	2	0	0	34
		79%	12%	3%	6%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
4	Will natural supports continue to be involved with your family when CSA Wraparound is finished?	26	1	5	2	0	0	34
		76%	3%	15%	6%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
5	Does your care coordinator help you to identify and help you to work on the needs that are most important to your family?	28	5	0	0	1	0	34
		82%	15%	0%	0%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
6	Has your care coordinator improved your confidence and ability to get your family's needs met?	29	1	3	0	1	0	34
		85%	3%	9%	0%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
7	Does your care coordinator use your family's voice and choice in the problem solving process?	29	2	2	0	1	0	34
		85%	6%	6%	0%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
8	Does your care coordinator provide opportunities to celebrate and mark your accomplishments?	26	4	2	0	0	2	34
		76%	12%	6%	0%	0%	6%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						

FY 2014 Annual Member Satisfaction Survey Data Results

Q#	QUESTION	STRONGLY AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NOT ANSWERED	TOTAL RESPONSES
9	Does your care coordinator provide you with information about community, advocacy resources, and ways to connect with others?	28	0	3	2	1	0	34
		82%	0%	9%	6%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	91%						
10	Does your care coordinator pay attention and demonstrate sensitivity to your preferences and culture?	29	2	2	1	0	0	34
		85%	6%	6%	3%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
11	Are natural supports engaged in the planning and the implementation process of Wraparound efforts?	21	4	7	1	1	0	34
		62%	12%	21%	3%	3%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
12	Are community-based ideas brainstormed, prioritized, and utilized in care planning meetings?	26	2	4	0	1	1	34
		76%	6%	12%	0%	3%	3%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	94%						
13	Is your family confident that in the occurrence of a crisis, the team can keep your child in the community?	27	3	3	1	0	0	34
		79%	9%	9%	3%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	97%						
14	Does your care coordinator help create a team of people to work on your family-driven plan based upon your vision?	29	1	1	3	0	0	34
		85%	3%	3%	9%	0%	0%	
	STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	91%						
		379	35	36	13	8	5	

Families that received surveys	220
Families declined to participate.	201
Family submitted a blank survey.	0
Families who submitted written comments.	24
Families who submitted surveys without written comments.	10

Family Support Partner (FSP)
Skill Sets, Functions, and Roles

Functions of the Family Support Partner

1. Partner with the Wraparound Staff (Wraparound Facilitator, Youth Support Partner and Wraparound Coach) to ensure that the wraparound process is provided with high fidelity and is successful for families.
2. Provide direct support to parents and child and family team members to carry out action steps from the wraparound plan.
3. Connect families to other families to strengthen natural supports and provide system level family voice and choice.

Family Support Partner Roles

- The FSP role models effective personal interactions and behavior.
- The FSP advocates for and supports families to identify their own strengths, needs, culture and vision and get these needs met.
- The FSP shares their own experiences to build relationships with and help families be successful with wraparound.
- The FSP mentors families to improve their confidence and ability to advocate for and effectively manage the services and supports for their own family.
- The FSP supports development, reconnection and strengthening of natural supports for families.
- The FSP partners with the wraparound staff (e.g., wraparound facilitator, youth support partner, and wraparound coach) to provide a high fidelity wraparound process.
- The FSP supports development of Family to Family Supports. .

Family Support Partner Skill Sets for Roles

<u>Models Effective Interactions</u>

1. The FSP encourages and models commitment to the family and encourages the family to believe in their future and to stick with the process.
2. The FSP honors the culture of the family by keeping their own views in check.
3. The FSP aligns themselves with the family to support the family's choices.
4. The FSP engages in strategic and mutually respectful partnerships with the facilitator, youth support partner and other team members.
5. The FSP role models strengths-based interactions by not blaming or shaming others in the presence of the family or other team members.
6. The FSP models protection of confidentiality by never talking about wraparound families outside of the appropriate work setting, without the families' permission and input.
7. The FSP checks in with the family during and at the end of interactions and activities to determine family satisfaction with the process.

Advocates for and Supports Families Needs

8. The FSP help the family understand that support can take on many different forms and that the family will determine what the support will look like for them.
9. The FSP actively listens to the family and takes notes about support needs, clarifying points with the family and facilitator.
10. The FSP shares experiences with families to help them understand how wraparound can help families meet positively framed needs.
11. The FSP educates and supports family members to use their own voice to express their needs and preferences (e.g., "do for, do with, and cheer on").
12. The FSP supports self advocacy by providing the least amount of support that will be successful with planned fading of support (do for, do with and then cheer on).
13. The FSP recognizes and values the differences among families, discovering the unique culture of each family and using this information to determine how they can best advocate for their family.
14. The FSP helps family members understand and to explain their culture and strengths to get their plan to match their family culture.
15. The FSP understands family needs, culture, strengths and preferences and supports families to advocate for them.
16. The FSP helps the family understand the mandates and perspective of other team members, while keeping family perspective at the forefront of team discussions.

Sharing Your Experience

17. The FSP shares their own experiences to develop a shared sense of understanding and relationship with families.
18. The FSP may share their own experience with wraparound to give the family an understanding of how the process can be an opportunity for them.
19. The FSP may share their own experience with the different activities of the wraparound process to give the family an understanding of how the process can affect them.
20. The FSP may prepare the family for the strengths, needs, and culture discovery conversations through sharing personal and other family experiences.
21. The FSP may give personal examples to help clarify questions.
22. The FSP share their own experience of how being honest and open helped them to get better support.

Mentors Families to Improve Self Efficacy (Confidence they can be successful)

23. The FSP observes and interacts with the family to help the family understand and celebrate strengths.
24. FSP knows available resources within a community and helps the families in choosing and accessing those that address their needs.
25. The FSP educates and supports the family in the importance of maintaining and using documentation to advocate and control the process of service and support.
26. The FSP helps families to understand how to store and use documentation to support services for their children.
27. The FSP helps and encourages families to find and develop effective self advocacy skills.

Supports Development, Reconnection and Strengthening of Natural Supports for Families

28. The FSP may share personal experiences and reasons why natural supports can be important for families.
29. The FSP helps families identify reciprocal relationships (what each person gets from the relationship) that define and sustain natural supports.
30. When families do not easily identify natural supports an FSP may be enlisted to do more in depth work with the family to identify potential supports.
31. The FSP may work with the family to plan for contacting potential natural support team members and orienting them to the process.
32. The FSP may meet with natural supports to get them ready for initial or follow-up wraparound meetings.
33. The FSP helps families to plan and reconnect with extended family and natural supports based on family voice and choice.
34. The FSP helps families and natural supports work through barriers to partnership.

Supports Implementation of the Phases and Activities of Wraparound. (The FSP partners with the wraparound facilitator and youth support partner to complete the activities of the wraparound process).

Wraparound Phase One: Engagement

35. The FSP may assist the wraparound facilitator by doing one on one orientation, sharing their own experience with wraparound, and helping the family to understand how wraparound might be a positive opportunity for them.
36. The FSP helps the family understand what is different about wraparound by explaining wraparound from a family's perspective.
37. The FSP may provide written materials and other resources to help families understand wraparound, review these materials with the family and answer questions.
38. The FSP explains their role including what they may do and limits on the role.
39. The FSP may assist the wraparound facilitator in explaining confidentiality and client rights and responsibilities, and as needed, help ease these fears and answer questions from a family perspective.
40. The FSP may assist in the development of crisis stabilization plans to make sure the plans are individualized, based on voice and choice and are realistic for the family.
41. If a family member is very distrustful of systems and does not want to sign consent and release forms, the FSP may need to do some one on one time with the family member to help them understand why sharing could benefit their family.
42. The FSP may help the family prepare for the SNCD by helping the family identify their strengths, needs, culture and vision from a family perspective.
43. The FSP may help the family prepare for the SNCD by understanding why wraparound works better when focused on positive needs and reframing negative concerns into positive needs.
44. The FSP may help the family to gather and organize information that they will need to advocate for their child.

45. The FSP observes the SNCD conversations to ensure that the family does not answer questions in the way they think the wraparound facilitator wants them to answer, and is the truth teller or negotiator of this issue should it arise.
46. The FSP may take the completed summary document to the family and sit with them and go over it to make sure it is correct and to add to the document as needed.
47. The FSP may be able to help the family find natural supports within the community to help with the planning process.
48. The FSP may spend additional time with the family to prepare them for the initial wraparound meetings making sure they understand each of the parts of the agenda and are prepared to use their voice and choice.
49. If the family wants the FSP at planning meetings the FSP works with the family to decide the role the FSP will play in advance of the meeting.
50. The FSP works with the wraparound facilitator and youth support partner to make sure family needs are met in the scheduling, location and agenda for the wraparound planning meetings .
51. The FSP may contact team members who will need support to get to the meeting and to participate in the meeting.

Wraparound Phase Two: Planning

52. The FSP helps other team members to understand the importance of and feel comfortable with family voice and choice.
53. The FSP encourages thinking beyond the usual services and supports.
54. The FSP is determined to ensure family voice and choice during needs selection. Ideally, the FSP comes to the meeting with an understanding of family wishes in this area (and on goals and objectives).
55. The FSP agrees to take on action steps that are compatible with their role and that they have the time and resources to complete them.
56. The FSP is careful to ensure that the family understands the reason for the crisis plan and why it is being done.
57. The FSP explains the functional assessment process and shares how this process has helped other families and the importance of in-depth accurate information.
58. The FSP checks in with the family to ensure they feel they were heard and that the developed plan is individualized to who they are and is realistic.

Wraparound Phase Three: Implementation

59. The FSP reviews the written plan with the family to make sure they understand it, agree with it and have any resources or supports needed to implement it.
60. The FSP encourages the family in completing action steps, through motivation, support, reminders.
61. The FSP works with the family to determine if the plan is working and to decide when they need to ask for changes in the plan.
62. The FSP checks with the family on emerging needs and if the needs should be brought to the team and if new strategies are needed.
63. The FSP may help the family to update their various documents and information used to advocate for their child and family, helps the family to identify the strengths of their

natural support systems and communities and helps them identify ongoing needs to be more connected as needed.

64. The FSP constantly checks with the family on their feeling of support from the team, and if they are beginning to feel a lack of support, too much support, or if the family is not content with the team for any reason.
65. The FSP can be used to spend additional time with the family to prepare them for follow-up wraparound meetings.
66. The FSP works creatively with the family and their team to make sure that progress does not stop when barriers and challenges occur.
67. The FSP models positive collaboration with all team members to build team cohesion (togetherness).
68. The FSP documents their work with the family through progress notes that meet the criteria set by the participating agencies.

Wraparound Phase Four: Transition

69. The FSP supports the family to identify the needs that will continue to need attention after formal wraparound ends.
70. The FSP helps the family to identify the successes they have had and the lessons they have learned through the wraparound process.
71. The FSP checks in with the family to ensure that the modification to the wraparound process is understood and is culturally competent to the family.
72. The FSP checks with the family to see how and if they would like to celebrate success in a culturally competent manner.
73. Ideally the FSP should be committed to remaining with the family as long (and no longer) than the family needs / desires. The FSP supports the family through self-advocacy. Phasing out the FSP should be a gradual process as families expand their role.

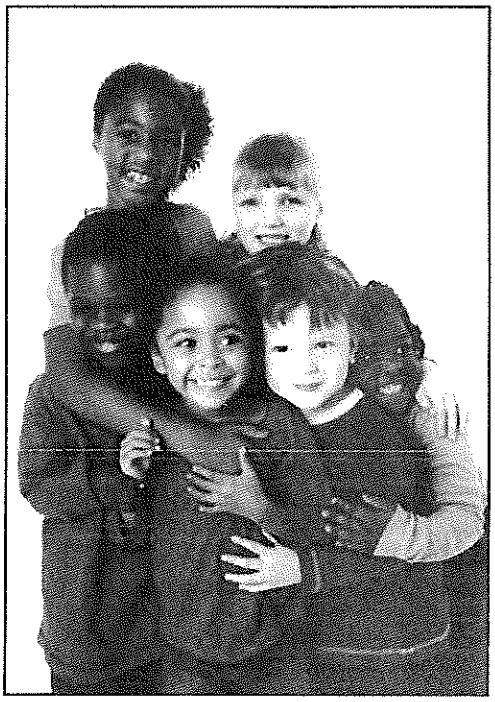
<u>Supports Development of Family to Family Supports</u>

74. The FSP may link the family up with other graduates of the process who can be team members and natural supports.
75. The FSP gives families opportunities to become part of the larger circle of families where they can find support from other parents and caregivers with similar experiences.
76. FSPs connect families to local family groups and organizations.

Massachusetts Wraparound Fidelity Assessment System

Wraparound Provider Practice Analysis

Community Counseling of Bristol County- Attleboro



Fifth Edition: September 2014

Developed by MBHP in Collaboration with the Wraparound Evaluation and Research Team

Department of Psychiatry, University of Washington

Public Behavioral Health and Justice Policy

CBHI Children's Behavioral Health Initiative

MBHP Massachusetts Behavioral Health Partnership

LIST OF ACRONYMS

CANS	Child and Adolescent Needs and Strengths
CBHI	Children's Behavioral Health Initiative
CPT	Care Planning Team
CSA	Community Service Agency
FS&T	Family Support and Training
ICC	Intensive Care Coordination
ICM	Intensive Clinical Manager
IHBS	In-Home Behavioral Services
IHT	In-Home Therapy
PCC	Primary Care Clinician
SED	Severe Emotional Disturbance
TM	Therapeutic Mentoring

BACKGROUND

When the district court ruled in *Rosie D. v. Romney* that youth in Massachusetts were not receiving adequate behavioral health screenings, community-based care, or service coordination, work was begun to develop a remedial plan. The result is the CBHI, established as a means of strengthening, expanding and integrating state services into a comprehensive, community-based system of care for youth and families. The initiative is a collaborative effort of health care providers, consumers, advocacy groups, state agencies, managed care entities and other stakeholders.

Among the key components of the CBHI is the provision of *wraparound* care coordination for youth living with a serious emotional disturbance. During *wraparound*, a care coordinator affiliated with one of the state's 32 community service agencies works with the youth's family to convene a care planning team. Using the results of a comprehensive clinical assessment inclusive of the MA CANS, the team works together to develop an individual care plan and safety plan (and other Crisis Planning Tools chosen by the family) tailored to meet the youth's needs.

CBHI Mission

Strengthen, expand and integrate Massachusetts services into a comprehensive, community-based system of care so that families and their children with significant behavioral, emotional or mental health needs can obtain the services necessary for success in home, school and community.

Wraparound is not a form of treatment, but rather a process for coordinating service delivery for youth with complex needs. Intensive home and community-based services offered to youth and families engaged in *wraparound* include in-home therapy, in-home behavioral services, therapeutic mentoring, family support and training, and mobile crisis intervention.

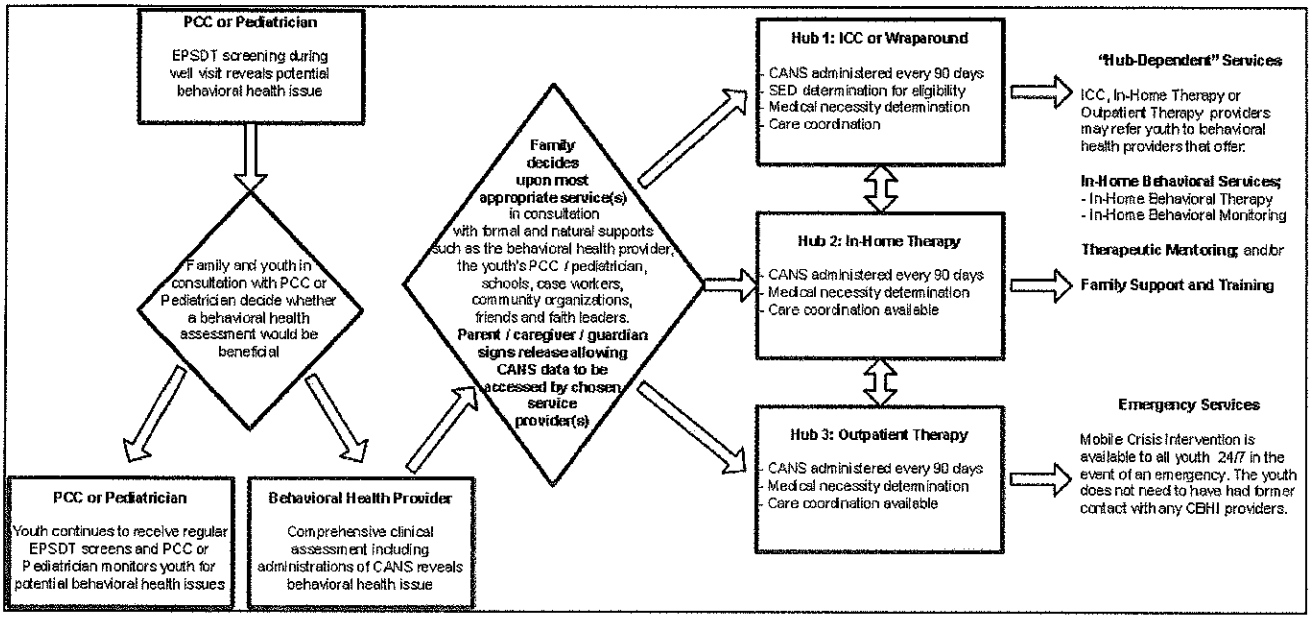


Figure 1: This diagram shows how youth access Wraparound services, from the initial behavioral health assessment (left), to an encounter with the "hub" service (middle), to referral for additional services (right).

Seven experimental and six quasi-experimental studies have compared outcomes of traditional interventions for youth to outcomes from interventions that incorporate *wraparound*. Two findings of particular importance to providers are that to be successful, *wraparound* programs must display *fidelity* and be targeted to youth who meet medical necessity.[1]

Typically we define *fidelity* as the degree to which a program is implemented as intended by its developers. Since *wraparound* wasn't developed by an individual or team – but rather through a collaborative process spearheaded by the National Wraparound Initiative (www.nwi.pdx.edu) – the definition of *wraparound fidelity* has been shaped by multiple individuals and organizations. In this analysis, wraparound fidelity is defined as the degree to which providers (a) adhere to the principles of quality wraparound and (b) carry out the basic activities of facilitating a wraparound process.

This document was developed as a tool for providers to gauge the degree to which their CSAs exhibit *wraparound fidelity* and to identify strengths and areas for improvement. The following pages summarize findings from the Massachusetts Wraparound Fidelity Assessment System (WFAS). This system encompasses the Wraparound Fidelity Assessment, Version 4 (MA WFI-4) and the Team Observation Measure (MA TOM).

[1] Bruns E, Leverentz-Brady K, Suter J. 2008. Is it Wraparound Yet? Setting Quality Standards for Implementation of the Wraparound Process. *Journal of Behavioral Health Services & Research* **35**(3): 240-252.

HOW TO USE THIS PROVIDER PRACTICE ANALYSIS

The Massachusetts Fidelity Assessment System was developed as a means for providers to monitor the fidelity of their Community Service Agencies to the principles and activities of Wraparound. Research shows that the attainment of high fidelity scores at the care team and program levels is associated with positive youth and family outcomes.[2] Fidelity monitoring also lays the groundwork for measuring the outcomes and efficiency of the Children's Behavioral Health Initiative over time.

This Wraparound Provider Practice Analysis is organized into four sections:

Section 1: Massachusetts Team Observation Measure Results (pp. 6 – 17)

Section 2: Massachusetts Wraparound Fidelity Index Results (pp. 18 – 24)

Section 3: Relative Strengths and Areas for Improvement (pp. 25 – 27)

Sections 1, 2 and 3 present customized results of the MA TOM and MA WFI-4 for **Community Counseling of Bristol County- Attleboro**. Each section begins with a summary of the methods by which the measure is administered and the items are scored. Findings are then presented in three ways, starting with broad summaries and then moving to more detailed analyses:

1. Total **Fidelity scores** are presented alongside the average Fidelity score for all CSAs ("state mean") and the average Fidelity score for all states that have participated in the TOM or WFI ("national mean");

2. **Principle scores** are presented for each of the 10 principles of Wraparound. These scores are presented alongside the average Principle score for all CSAs ("state mean") and the average Principle score for all states that have participated in the TOM or WFI ("national mean"); and

3. **Item scores** are presented for each of the items corresponding to the 10 principles of quality Wraparound. These scores are presented alongside the average Item scores for all CSAs ("state mean") and the average Item scores for all states that have participated in the TOM or WFI ("national mean.")

Until recently, CSA scores would have been difficult to interpret due to a lack of external criteria or norms against which to compare them. To overcome this barrier, the Wraparound Evaluation and Research Team compiled a national database of TOM and WFI data. This is what allows us to compare your CSA's scores to the national mean. National means were calculated by averaging scores across all TOMs and WFI-4 caregiver interviews completed outside of Massachusetts. The means were updated in FY 2012 to include observations and interviews completed between July 2009 and June 2012.

[2] Suter J, Bruns E. 2009. Effectiveness of the Wraparound Process for Children with Emotional and Behavioral Disorders: A Meta-Analysis. *Clinical Child and Family Psychology Review* **12**(4): 336-351.

The final section of the Wraparound Provider Practice Analysis contains a summary of the results from the MA TOM and MA WFI-4, including a listing of strengths and areas for improvement.

To read more about measuring wraparound fidelity, consider visiting the National Wraparound Initiative homepage and clicking on "assessment/fidelity": http://www.nwi.pdx.edu

To read more about psychometrics, reliability and validity of the WFI, go to http://depts.washington.edu/wrapeval/docs and download the document entitled "Psychometrics…" A study of the psychometrics, reliability and validity of the TOM is expected to be published in FY2013 and will be posted on the National Wraparound Initiative Web site.

Ten Principles of Wraparound

1. Family Voice and Choice
2. Team-Based
3. Natural Supports
4. Collaboration
5. Community-Based
6. Culturally Competent
7. Individualized
8. Strengths-Based
9. Unconditional
10. Outcome-based

For detailed information on the *Principles of Wraparound*, please see **Appendix A.**

CBHI Vision

A behavioral health care system where policies, financing, management and delivery of publicly-funded behavioral health services are integrated to make it easier for families to find and access appropriate services, and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

CBHI Values

- **Strengths-based:** Services are built on the strengths of family and their community.
- **Family-Driven, Youth-Guided:** Services are driven by the needs and preferences of the child and family, and are developed in partnership with and are accountable to families.
- **Culturally Responsive:** Services are responsive to the family's values, beliefs, norms, and to socioeconomic and cultural context.
- **Continuous Improvement:** Service improvements reflect a culture of continuous leaning, and are informed by data, family feedback, evidence and best practice.
- **Collaborative and Integrate:** Services are integrated across child-serving agencies and programs.

SECTION 1: MASSACHUSETTS TEAM OBSERVATION MEASURE (MA TOM)

Background from the NWI Resource Guide to Wraparound

The Massachusetts Team Observation Measure (MA TOM) assesses adherence to standards of high-quality wraparound during team meeting sessions. It was originally developed to be used by external evaluators, but has also been used by supervisors to help support coaching and supervision of wraparound staff. The MA TOM consists of 20 items, with two items dedicated to each of the 10 principles of wraparound. Each item consists of up to 4 indicators of high-quality wraparound practice as expressed during a child and family team meeting. Trained raters indicate whether or not each indicator was in evidence during the wraparound team meeting session. These ratings are translated into a score for each item as well as a total fidelity score for the session overall.

Interpreting MA TOM Scores

Your CSA's FY2010, FY2011, FY2012, FY2013, and FY2014 total fidelity, principle and item/indicator scores are displayed on the following pages with comparisons to the state and national averages. To arrive at a principle score, the two item scores corresponding to each principle were summed, resulting in a score ranging from 0 (low fidelity) to 8 (high fidelity). Principle scores were then expressed as a percent of total possible fidelity. A principle score of 7 out of 8, for example, would be expressed as 87.4% fidelity.

MA TOM items are comprised of up to 4 indicators (denoted by letters a through d) that the observer assigns a "yes" or a "no." For each TOM, item scores were calculated using the following logic model, which takes into account the fact that each item is made up of a different number of indicators. Overall item scores represent the average of item scores across all TOMs completed by your CSA:

Number of Indicators	Number of Indicators Scored 'Yes'	Item Score
4	4	4
	3	3
	2	2
	1	1
	0	0
3	3	4
	2	3
	1	1
	0	0
2	2	4
	1	2
	0	0
1	1	4
	0	0

Indicators corresponding to each item are displayed as a percent, interpreted as the percent of time the indicator was assigned a 'yes.'

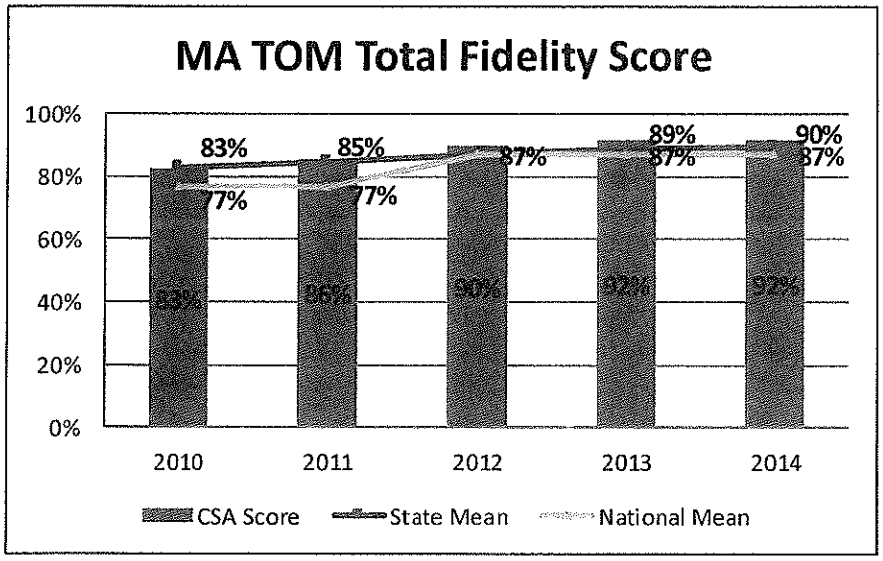
0	None of the indicators for this item were evident during the team meeting (i.e. none were scored 'yes')
1	Some, but fewer than half of the indicators for this item were scored 'yes'
2	About half of the indicators for this item were scored 'yes'
3	More than half, but not all, of the indicators for this item were scored 'yes'
4	All of the indicators for this item were evident during observation (i.e. all were scored 'yes')

Methods

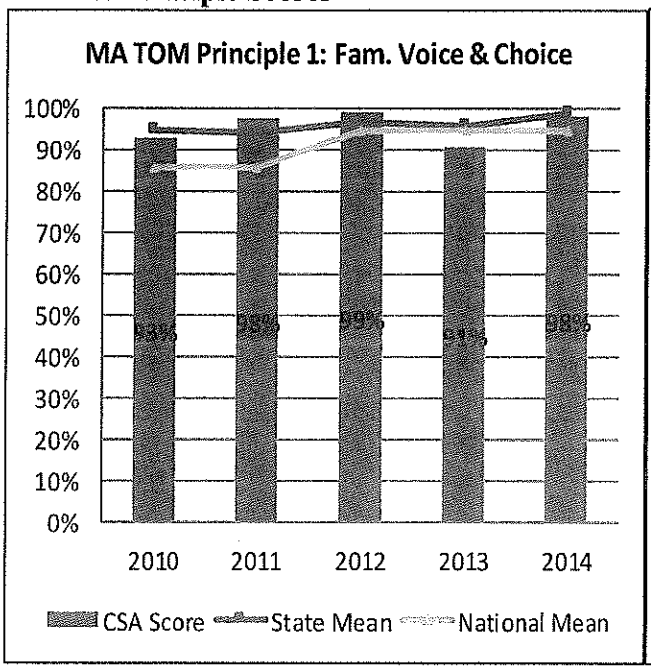
The MA TOM is one of two tools being used to monitor and evaluate (1) adherence to the principles of Wraparound, and (2) whether the basic activities of facilitating Wraparound are occurring. From July 1, 2013 through May 30, 2014, the MA TOM was administered by program supervisors during care team sessions led by intensive care coordinators (ICCs) carrying a caseload for four or more months. For existing ICCs, the requirement is that two TOMs be completed per year. For new ICCs, the requirement is that two TOMs be completed within months four and six from their date of hire. There were 717 TOM assessments completed and entered into WrapTrack in FY2014. This number includes 23 assessments from **Community Counseling of Bristol County- Attleboro**.

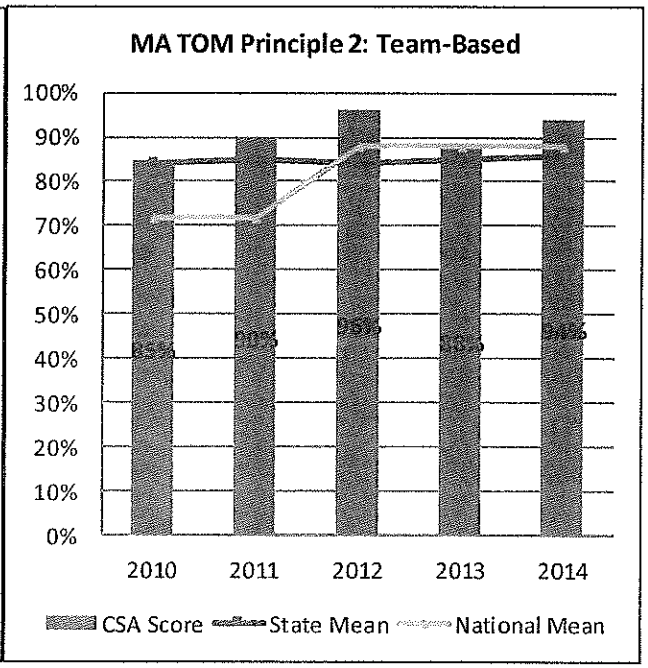
Results: FY2014 Total Fidelity and Item Scores

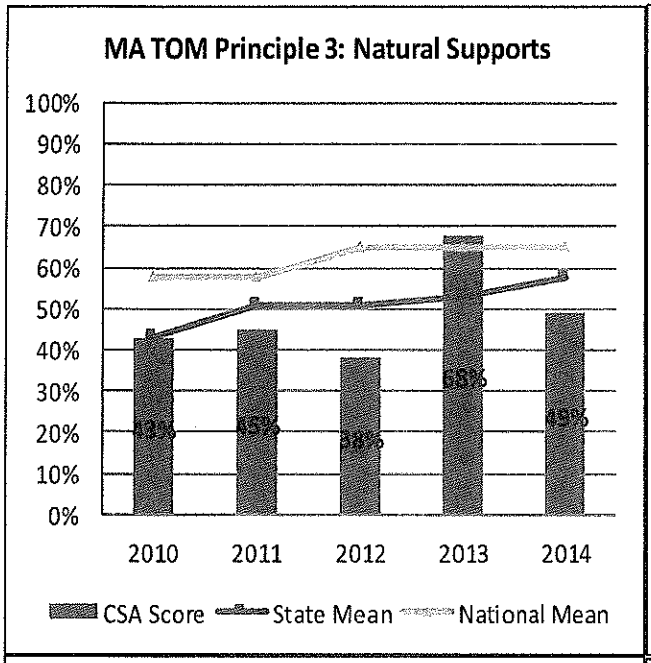
Item		CSA Score	State Mean	National Mean
1	Team Membership and Attendance	88%	76%	86%
2	Effective Team Process	100%	97%	91%
3	Facilitator Preparation	99%	95%	82%
4	Effective Decision Making	100%	97%	92%
5	Creative Brainstorming and Options	100%	94%	84%
6	Individualized Process	96%	97%	94%
7	Natural and Community Supports	38%	43%	47%
8	Natural Support Plans	60%	74%	83%
9	Team Mission and Plans	97%	94%	91%
10	Shared Responsibility	100%	98%	95%
11	Facilitation Skills	100%	96%	90%
12	Cultural and Linguistic Competence	100%	99%	96%
13	Outcomes-Based Practice	100%	91%	80%
14	Evaluating Process and Success	98%	92%	81%
15	Youth and Family Voice	99%	99%	98%
16	Youth and Family Choice	98%	98%	93%
17	Focus on Strengths	99%	95%	87%
18	Positive Team Culture	98%	97%	91%
18	Community Focus	85%	94%	89%
20	Least Restrictive Environment	99%	98%	98%
Total Fidelity Score: Average Fidelity score across TOMs (for CSAs and National Mean) or CSAs (for State Mean)		92%	90%	87%

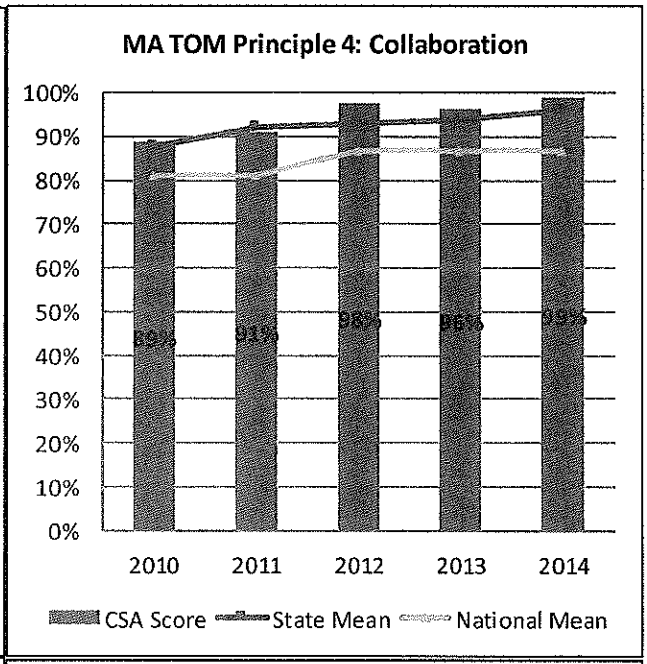


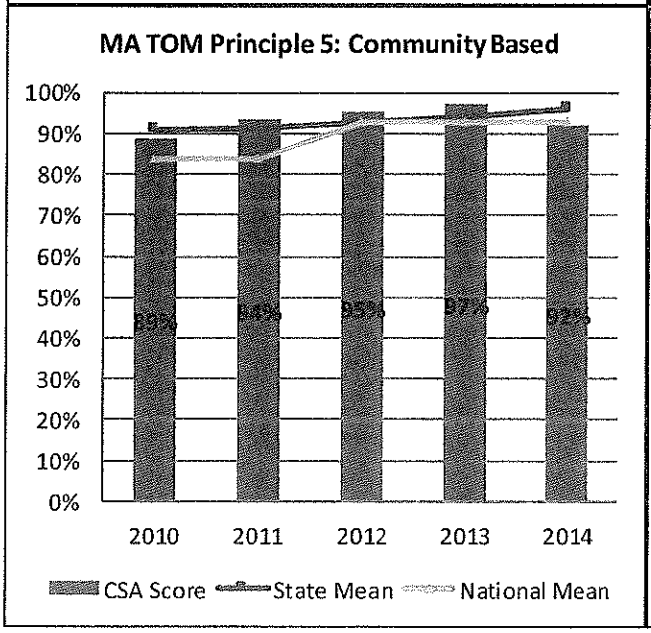
Results: Principle Scores

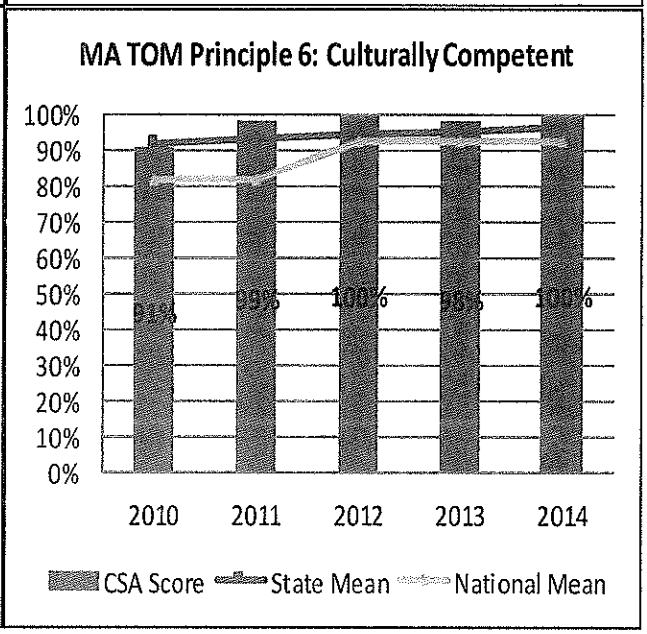


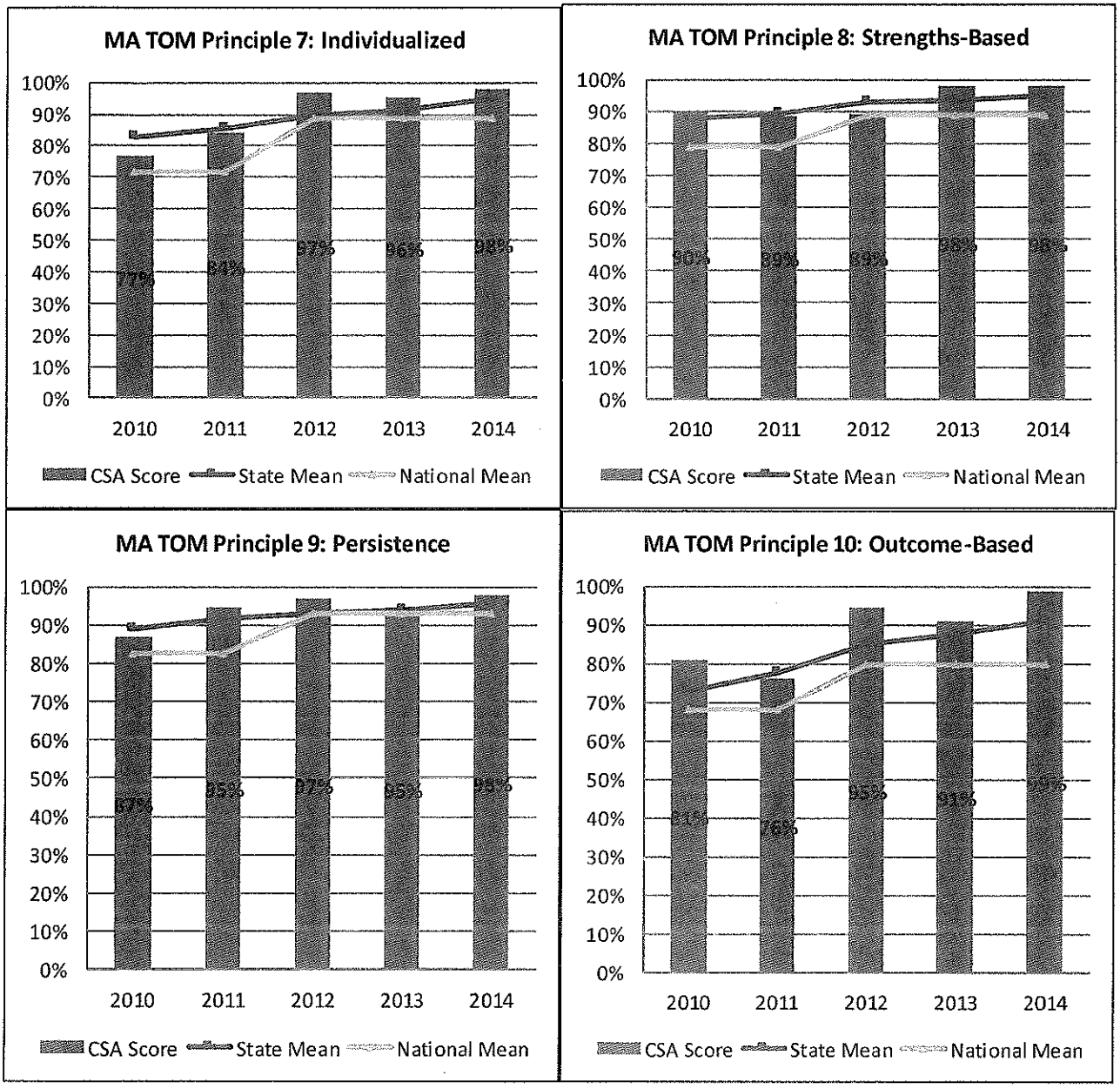



MA TOM Principle 3: Natural Supports
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean

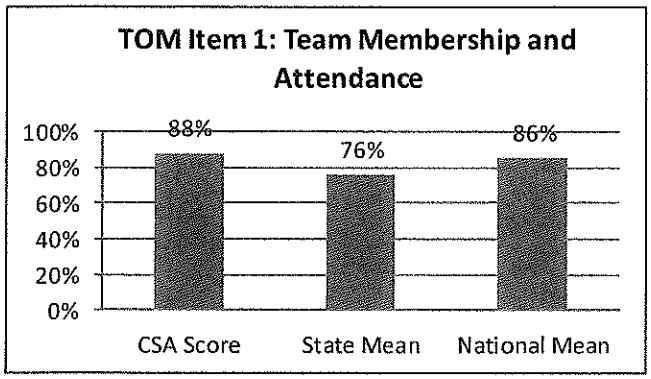

MA TOM Principle 4: Collaboration
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA TOM Principle 5: Community Based
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean

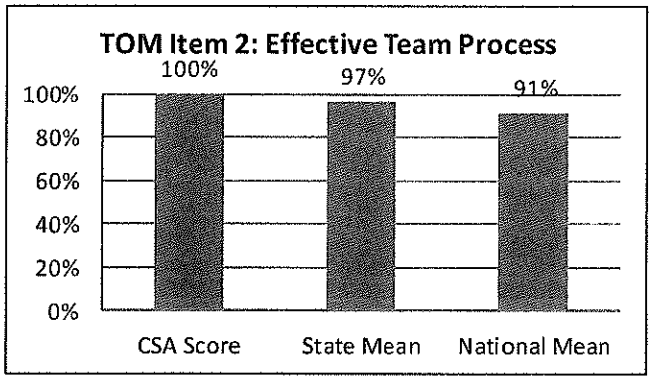

MA TOM Principle 6: Culturally Competent
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA TOM Principle 7: Individualized
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA TOM Principle 8: Strengths-Based
CSA Score
State Mean
National Mean
MA TOM Principle 9: Persistence
CSA Score
State Mean
National Mean
MA TOM Principle 10: Outcome-Based
CSA Score
State Mean
National Mean

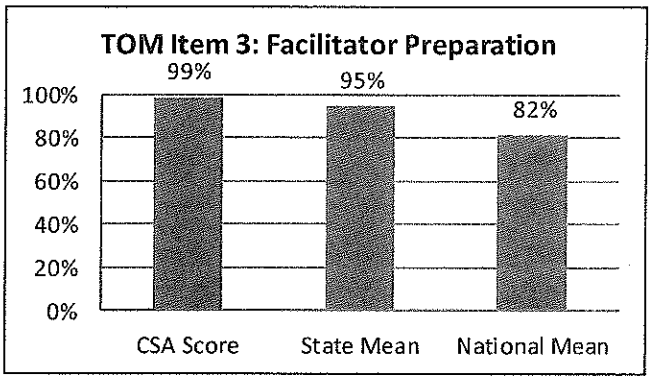
Results: FY2014 Item Scores



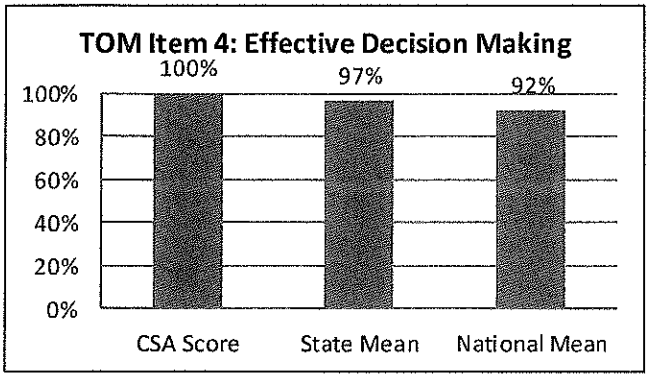
	Team Membership and Attendance	Mean score
		3.52
a	Parent/caregiver is a team member and present at meeting	100%
b	Youth (over age 9) is a team member and present at the meeting	77%
c	Key school and/or other public stakeholder agency representatives are present.	67%



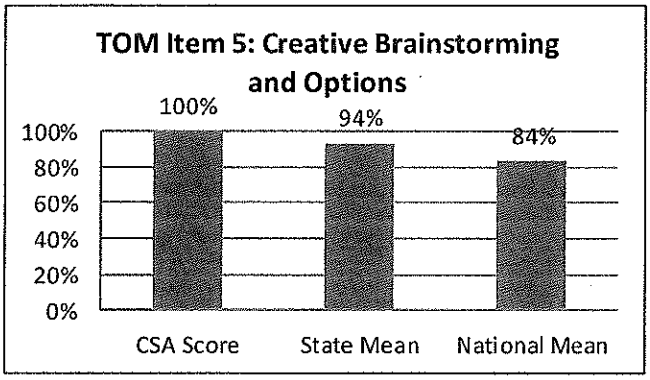
	Effective Team Process	Mean score
		4.00
a	Team meeting attendees are orientated to the wraparound process and understand the purpose of meeting	100%
b	The facilitator assists the team to review and prioritize family and youth needs	100%
c	Tasks and strategies are explicitly linked to goals	100%
d	Potential barriers to the nominated strategy or option are discussed and problem-solved	100%



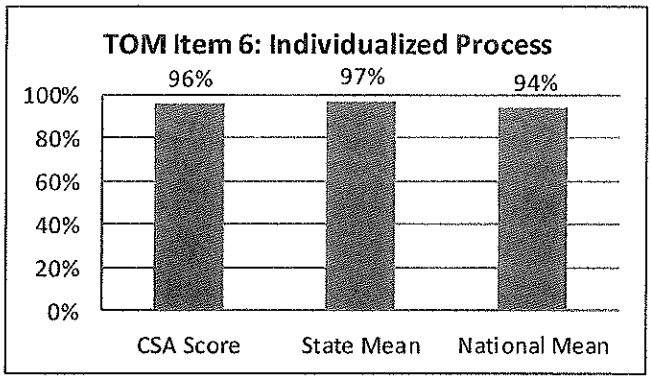
	Facilitator Preparation	Mean score
		3.96
a	There is a clear agenda or outline for the meeting, which provides an understanding of the overall purpose of meeting	100%
b	The meeting follows an agenda or outline such that team members know the purpose of their activities at a given time	100%
c	The facilitator has prepared needed documents and materials prior to the meeting	100%
d	A plan for the next meeting is presented, including time and date	95%



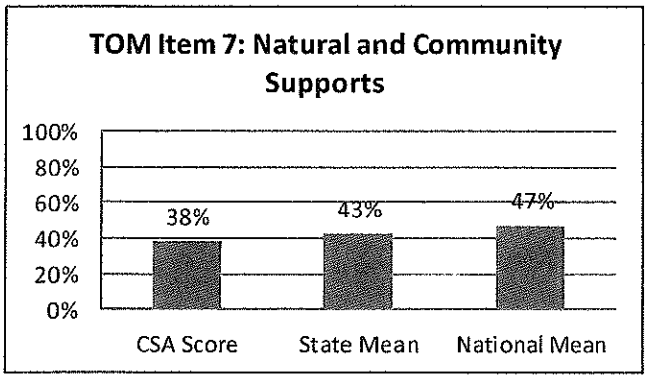
	Effective decision making	Mean score
		4.00
a	Team members demonstrate consistent willingness to compromise or explore further options when there is a disagreement	100%
b	Team members reach shared agreement after having solicited info from several members or having generated several ideas	100%
c	The plan of care is agreed upon by all present at the meeting	100%
d	The facilitator summarizes the content of the meeting at the end of the meeting, including next steps and responsibilities	100%



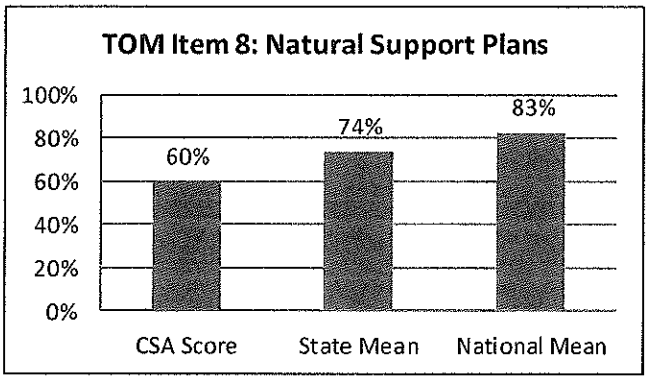
	Creative Brainstorming and Options	Mean score
		4.00
a	The team considers several different strategies for meeting each need and achieving each goal that is discussed	100%
b	The team considers multiple options for tasks or action steps.	100%
C	The facilitator leads a robust brainstorming process to develop multiple options to meet priority needs.	100%



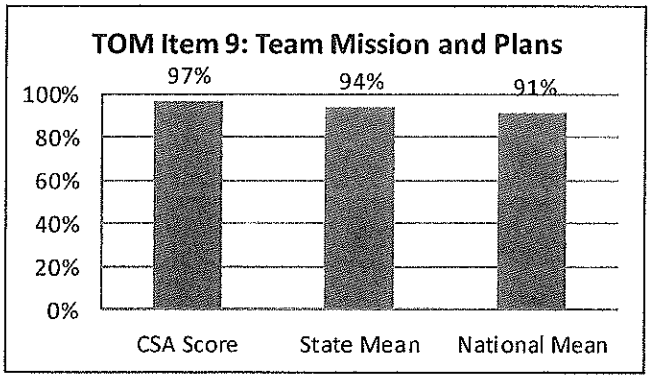
	Individualized process	Mean score
		3.83
a	Planning includes action steps or goals for other family members, not just identified child	91%
b	Facilitator and team members draw from knowledge about the community to generate strategies and action steps based on unique community supports	100%
c	Team facilitates the creation of individualized supports or services to meet the unique needs of child and/or family	96%
d	Youth, caregiver, and family members give their opinions about potential services, supports or strategies; including describing what has or has not worked in past	96%



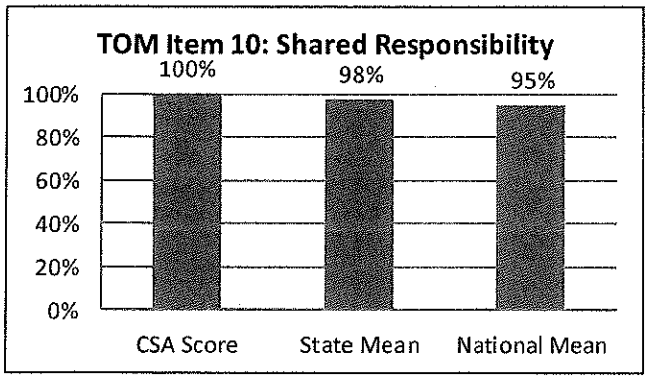
	Natural and community supports	Mean score
		1.52
a	Natural supports for the family are team members and present	26%
b	Team provides multiple opportunities for natural supports to participate in significant areas of discussion	69%
c	Community team members and natural supports participate in decision-making	42%
d	Community team members and natural supports have a clear role on the team	73%



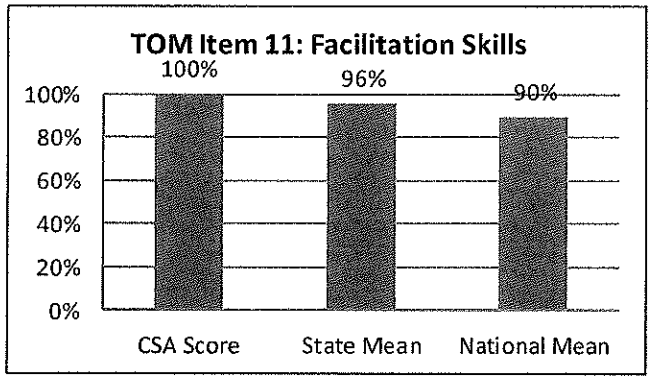
	Natural support plans	Mean score
		2.39
a	Brainstorming of options and strategies includes strategies to be implemented by natural and community supports	86%
b	The plan of care represents a balance between formal services and informal supports	43%
c	There is flexible funding available to the team to allow for creative services, supports and strategies	38%



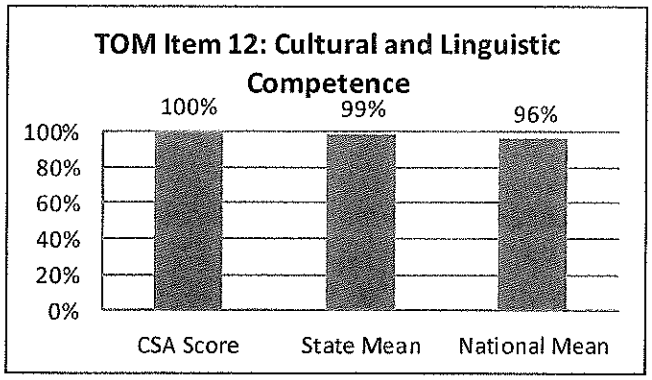
	Team mission and plans	Mean score
		3.87
a	The team discusses or has produced a mission/vision statement.	100%
b	The team creates or references a plan that guides its work	100%
c	The team has confirmed or is creating a crisis plan	87%
d	The team plan contains specific goals that are linked to strategies and action steps	100%



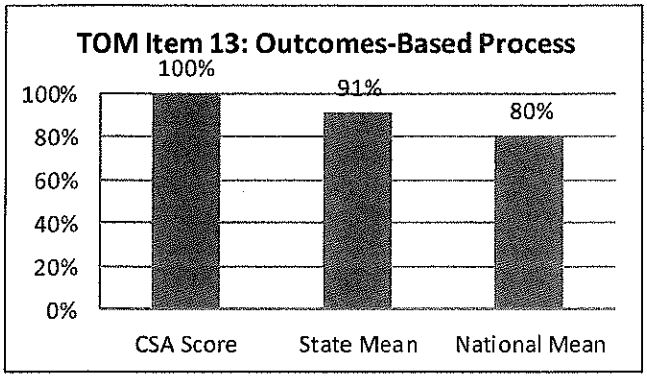
	Shared Responsibility	Mean score
		4.00
a	The team explicitly assigns responsibility for action steps that define who will do what, when and how often	100%
b	There is a clear understanding of who is responsible for action steps and follow up on strategies in the plan	100%
c	Providers and agency representatives at the meeting demonstrate that they are working for the family and not there to represent a different agenda or set of interests	100%



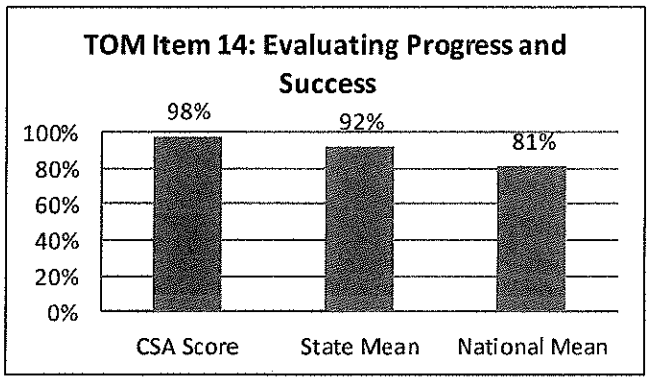
	Facilitation skills	Mean score
		4.00
a	Facilitator is able to impart understanding about what the wraparound process is, how it will work for this family, and how individual team members will participate	100%
b	Facilitator reflects, summarizes, and makes process-orientated comments	100%
c	Facilitator is able to manage disagreement and conflict and elicit underlying interests, needs, and motivations of team members	100%
d	Talk is well distributed across team members and each team member makes an extended or important contribution	100%



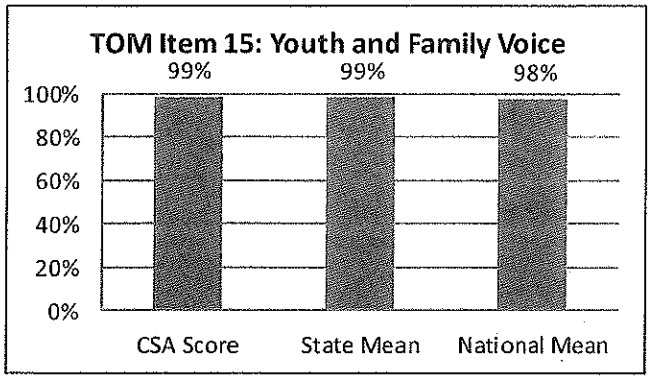
	Cultural and Linguistic Competence	Mean score
		4.00
a	The youth, caregiver, and family members are given time to talk about the family's values, beliefs, and traditions	100%
b	The team demonstrates a clear and strong sense of respect for the family's values, beliefs, and traditions	100%
c	Meetings and meeting materials are provided in the language the family is most comfortable with	100%
d	Members of the team use language the family can understand (i.e. no professional jargon or acronyms)	100%



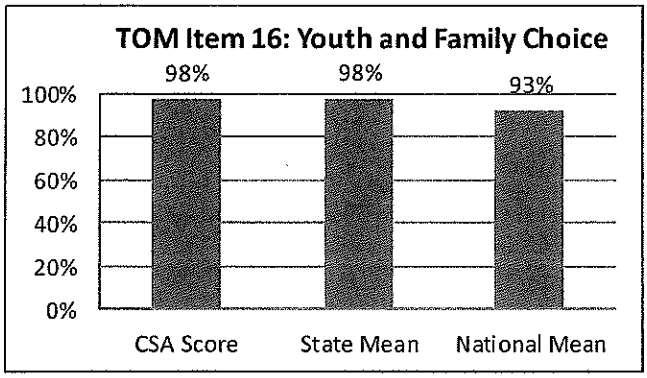
	Outcomes Based Process	Mean score
		4.00
a	The team uses objective measurement strategies	100%
b	The team assesses goals/strategies using measures of progress	100%
c	The team revises the plan if progress toward goals is not evident.	100%



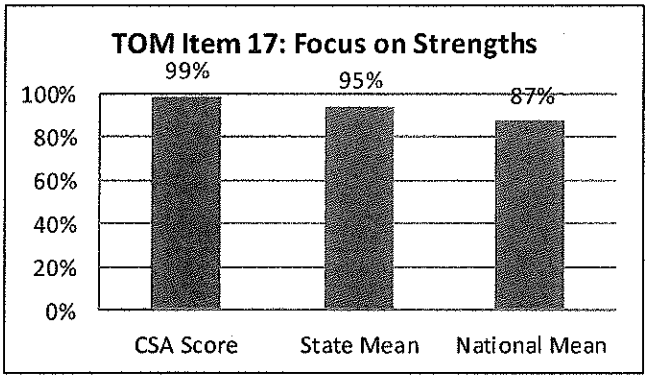
	Evaluating Progress and Success	Mean score
		3.91
a	The team conduces a systematic review of members' progress on assigned action steps	100%
b	The facilitator checks in with the team members about their comfort and satisfaction with the team process,	95%
c	Objective or verifiable data is used as evidence of success, progress, or lack thereof.	95%



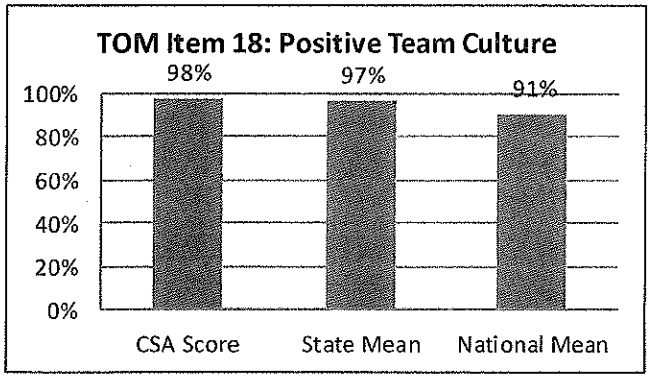
	Youth and Family Voice	Mean score
		3.96
a	The team provides extra opportunity for caregivers to speak and offer opinions, especially during decision making	100%
b	The team provides extra opportunity for the youth to speak and offer opinions, especially during decision making	100%
c	Caregivers, parents, and family members are afforded opportunities to speak in an open-ended way about current and past experiences and/or about hopes for the future	100%
d	The youth is invited to speak in an open-ended way about current and past experiences and/or about hopes for the future	92%



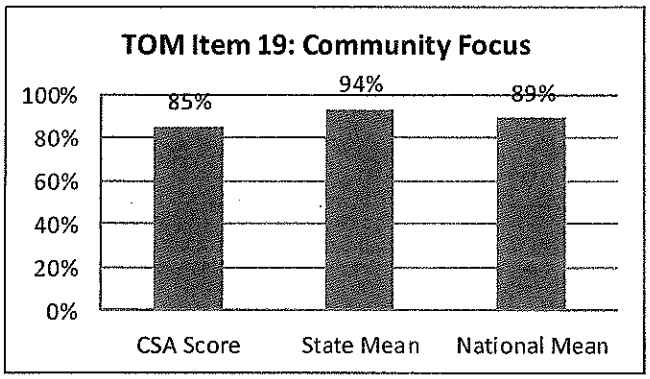
	Youth and Family Choice	Mean score
		3.91
a	The youth prioritizes life domains, goals, or needs on which she or he would like the team to work	92%
b	The caregiver or parent prioritizes life domains goals, or needs on which he or she would like the team to work.	100%
c	The family and youth have highest priority in decision making	96%



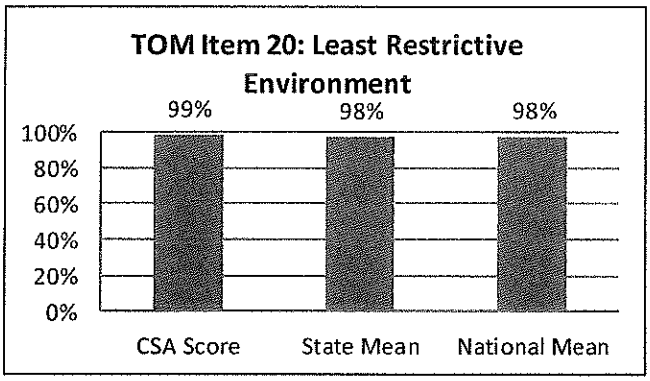
	Focus on Strengths	Mean score
		3.96
a	Team members acknowledge or list caregiver/youth strengths	100%
b	Team builds an understanding of how youth strengths contribute to the success of team missions or goals	100%
c	In designing strategies, team members consider and build on strengths of the youth and family	100%
d	Facilitator and team members analyze youth and family member perspectives and stories to identify functional strengths	96%



	Positive Team Culture	Mean score
		3.91
a	The team focuses on improvements or accomplishments throughout the meeting	100%
b	The facilitator directs a process that prevents blame or excessive focus on or discussion of negative events	96%
c	The facilitator encourages team culture by celebrating successes since the last meeting	100%
d	There is a sense of openness and trust among team members	96%



	Community Focus	Mean score
		3.41
a	The team is actively brainstorming and facilitating community activities for the youth and family	90%
b	The team prioritizes services that are community-based	77%
c	The team prioritizes access to services that are easily accessible to the youth and family	90%



	Least Restrictive Environment	Mean score
		3.96
a	The team's mission and/or identified needs support the youth's integration into the least restrictive residential and educational environments possible	100%
b	When residential placements are discussed, team chooses community placements for the child or youth rather than out-of-community placements, wherever possible.	80%
c	Serious challenges are discussed in terms of finding solutions, not placement in more restrictive residential or educational environments	100%

SECTION 2: MASSACHUSETTS WRAPAROUND FIDELITY INDEX, VERSION 4

Background from the NWI Resource Guide to Wraparound

The Massachusetts Wraparound Fidelity Index, Version 4 (MA WFI-4) is an interview that measures the nature of the wraparound process that an individual family received. The MA WFI-4 is completed through brief, confidential telephone interviews administered by staff of the consumer-led non-profit Consumer Quality Initiatives to caregivers of youth participating in Wraparound who have signed release of information forms. A demographic form is also part of the WFI-4. The WFI-4 interviews are organized by the four phases of the wraparound process. In addition, the 40 items of the WFI interview are keyed to the 10 principles of the wraparound process, with 4 items dedicated to each principle. In this way, the WFI-4 interviews are intended to assess adherence to the basic wraparound practice model, as well as fidelity to the principles of wraparound. WFI data can be used to assess the overall fidelity of an organization or wraparound initiative. Data can also be analyzed by phase, principle or item to help a program or supervisor make mid-course corrections.

Interpreting WFI Scores

Your CSA's FY2010, FY2011, FY2012, FY2013, and FY2014 total fidelity scores, principle and item scores are displayed on the following pages with comparisons to the state and national averages. To arrive at a total Principle score, the four item scores for each Principle were summed, resulting in a score ranging from 0 (low fidelity) to 8 (high fidelity). Principle scores were then expressed as a percent of total possible fidelity; a Principle score of 7 out of 8, for example, would be expressed as 87.4% fidelity.

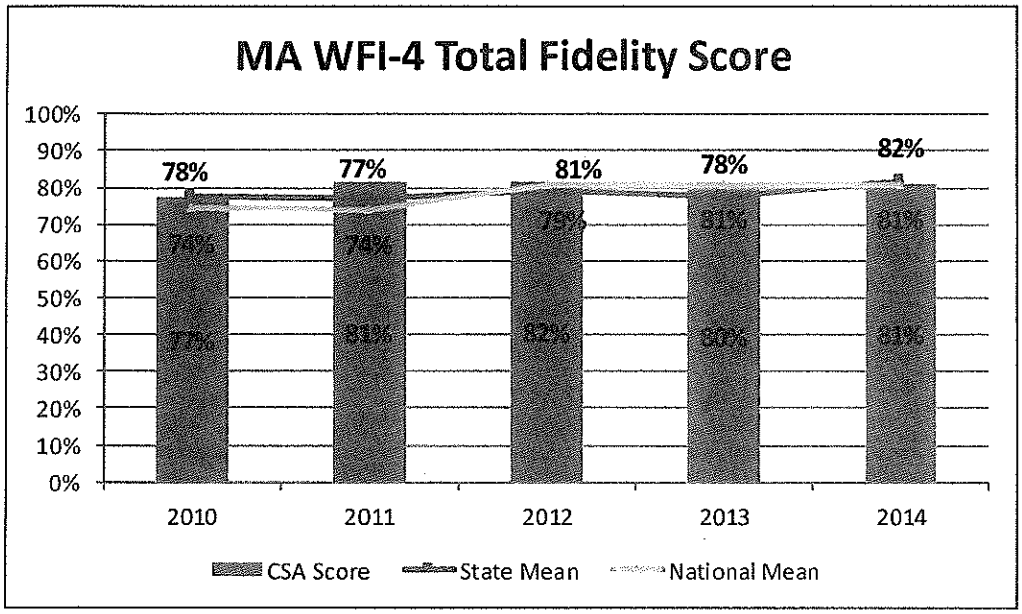
MA WFI-4 respondent forms include 40 items, corresponding to four items per Wraparound principle. For each item, caregivers' answers from the WFI interview were coded as "yes" (high fidelity), "somewhat or sometimes" (partial fidelity) or "no" (low fidelity). Item responses, which are presented on pp. 22-24, were then scored by the interviewer on a scale from 0 (low fidelity) to 2 (high fidelity).

When scoring the WFI, interviewers from CQI had to keep in mind that items are reverse-coded. For example, a "yes" response on a standard item (e.g., "Before your first team meeting, did your wraparound facilitator fully explain how the wraparound process would work?") would be scored a 2, indicating good Wraparound fidelity. However, a "yes" response to a reverse-coded item (e.g., "Is it difficult to get team members to attend team meetings when they are needed?") would receive a 0.

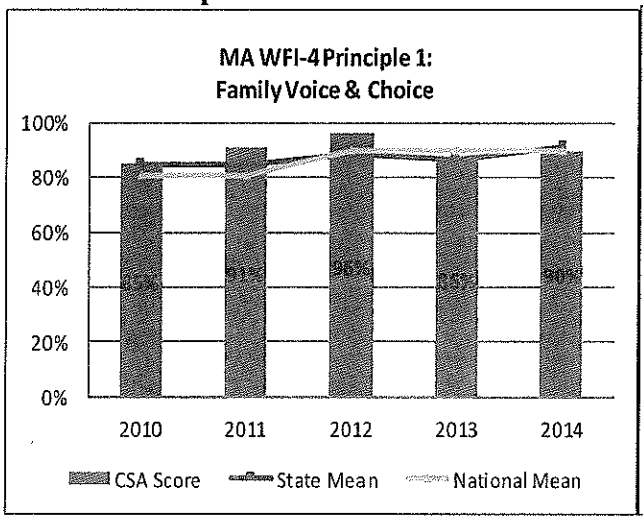
Methods

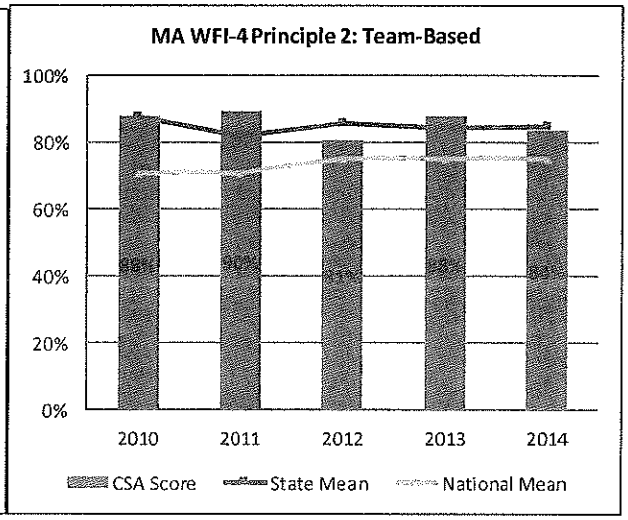
The Massachusetts Wraparound Fidelity Index, Version 4 (MA WFI-4) is one of two tools being used to monitor and evaluate (1) adherence to the principles of Wraparound, and (2) whether the basic activities of facilitating Wraparound are occurring. The MA WFI-4 was administered by staff of Consumer Quality Initiatives (CQI) from September 2013 through June 2014. During this time CQI interviewed caregivers of youth who enrolled in wraparound from January through December 2013, and who signed release of information forms. (Note that no caregivers interviewed for the MA WFI-4 FY2013 were re-interviewed). The requirement was that 20 WFI interviews be completed for each CSA – provided there were enough youth enrolled and, consequently, an adequate number of release forms. On June 30, the end of the data collection period, 629 MA WFI-4 assessments had been completed and entered into the online data and reporting system, WrapTrack. This number includes 20 interviews with caregivers of youth participating in Wraparound at **Community Counseling of Bristol County- Attleboro.**

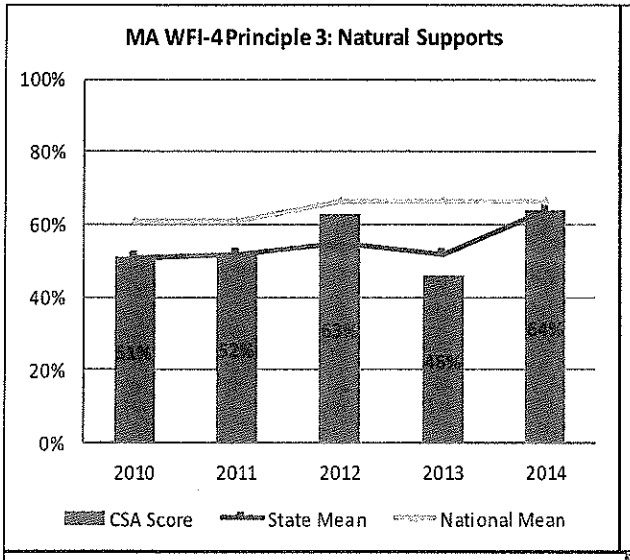
Results: Total Fidelity Score

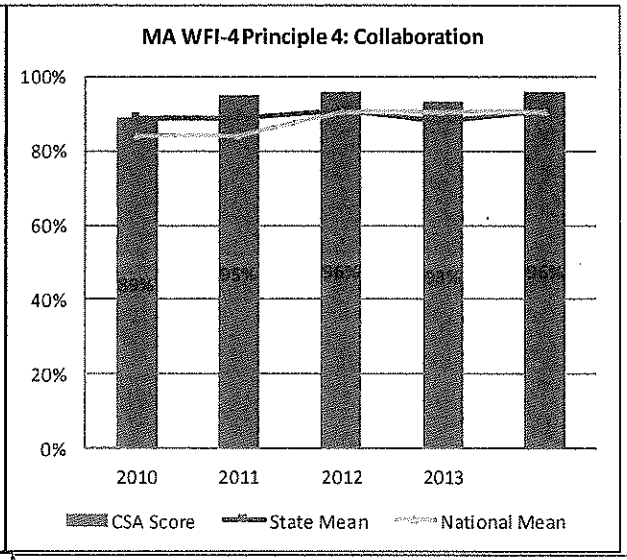


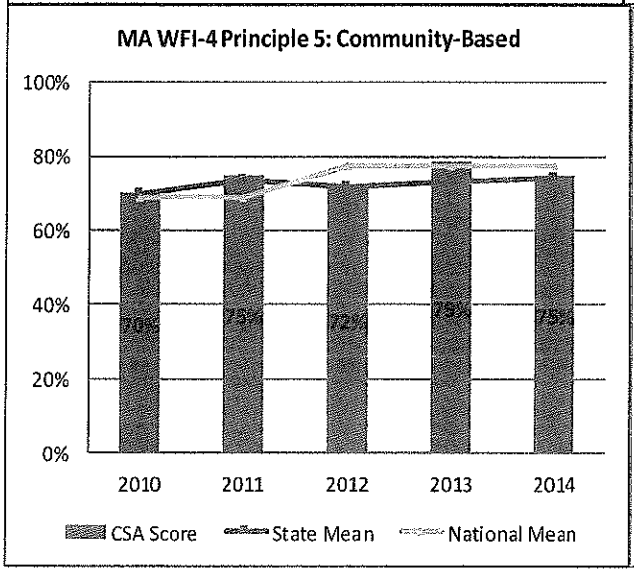
Results: Principle Scores

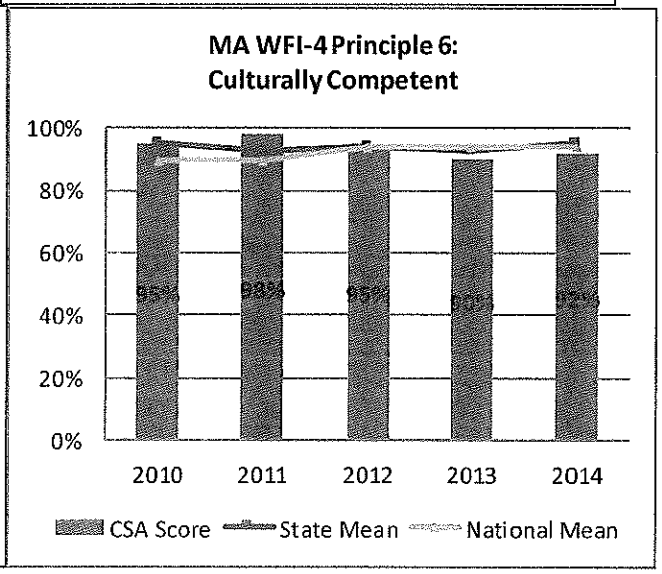


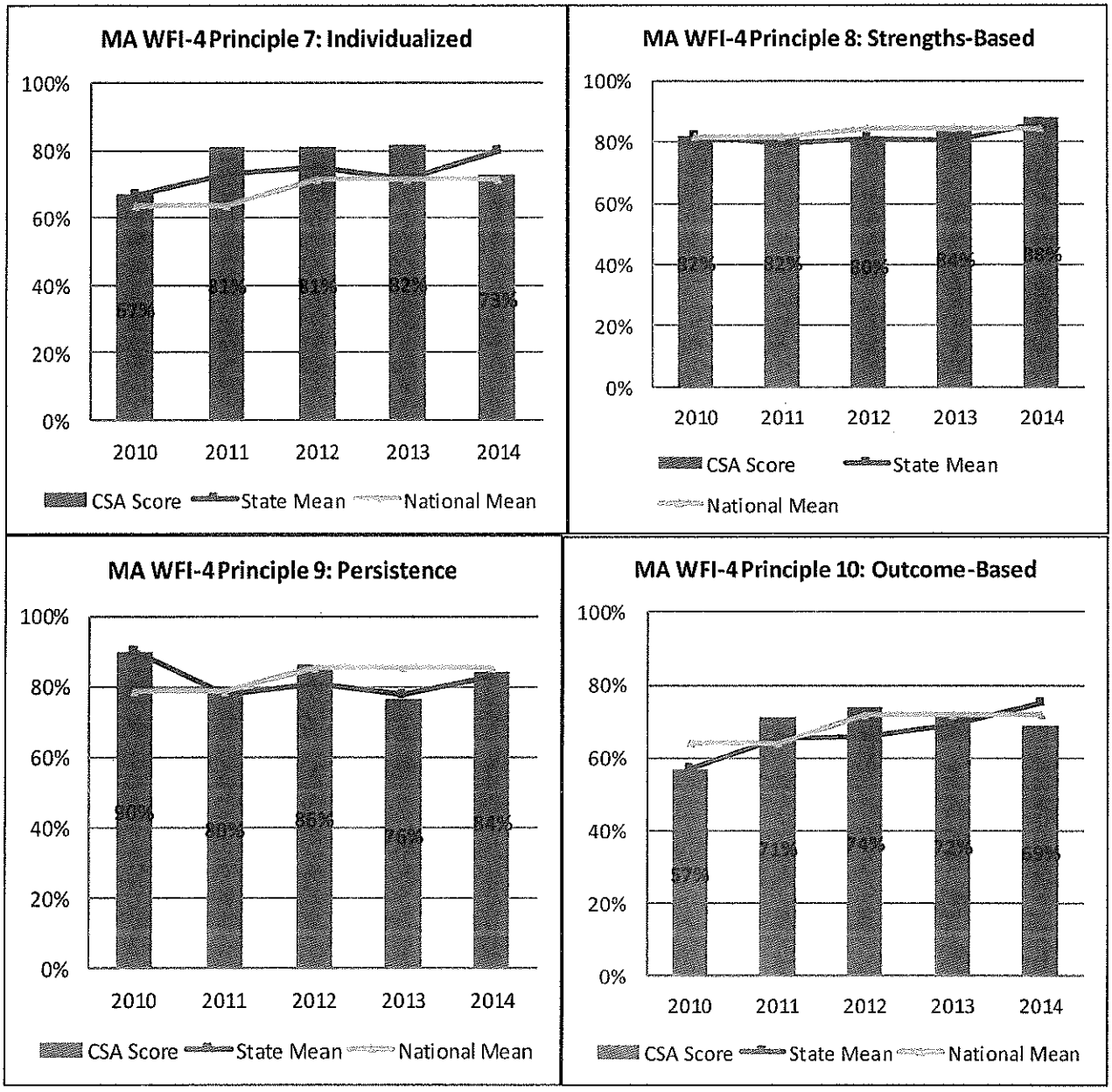



MA WFI-4 Principle 3: Natural Supports
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA WFI-4 Principle 4: Collaboration
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
CSA Score
State Mean
National Mean


MA WFI-4 Principle 5: Community-Based
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA WFI-4 Principle 6:
Culturally Competent
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean


MA WFI-4 Principle 7: Individualized
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA WFI-4 Principle 8: Strengths-Based
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA WFI-4 Principle 9: Persistence
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean
MA WFI-4 Principle 10: Outcome-Based
100%
80%
60%
40%
20%
0%
2010
2011
2012
2013
2014
CSA Score
State Mean
National Mean

Results: FY 2014 Item Scores

WFI Item		CSA Score	National Mean	National SD	State Mean	State SD
1.1 (CC)	When you first met with the family, were they given ample time to talk about their strengths, beliefs, and traditions?	1.68	1.82	0.50	1.85	0.10
1.2 (FVC)	Before the first team meeting, did you fully explain the wraparound process and the choices the family could make?	1.84	1.83	0.51	1.92	0.07
1.3 (SB)	At the beginning of the wraparound process, was the family given an opportunity to tell you what things have worked in the past for the child and family?	1.95	1.81	0.53	1.91	0.08
1.4 (TB)	Did the family members select the people who would be on their wraparound team?	1.45	0.93	0.95	1.40	0.26
1.5 (TB)	Is it difficult to get team members to attend team meetings when they are needed?	1.85	1.64	0.66	1.74	0.14
1.6 (OB)	Before the first wraparound team meeting, did you go through a process of identifying what leads to crises or dangerous situations for the child and family?	1.63	1.76	0.61	1.91	0.10
2.1 (Col)	Did the family plan and its team create a written plan of care (or wraparound plan, child and family plan) that describes how the team will meet the child's and family's needs?	2.00	1.78	0.53	1.93	0.08
2.2 (TB)	Did the team develop any kind of written statement about what the future will look like for the child and family, or what the team will achieve for the child and family?	1.60	1.63	0.69	1.78	0.16
2.3 (Ind)	Can you summarize the services, supports, and strategies that are in the family's wraparound plan?	0.80	0.74	0.84	1.25	0.26
2.4 (SB)	Are the supports and services in the wraparound plan connected to the strengths and abilities of the child and family?	1.95	1.85	0.45	1.85	0.10
2.5 (CB)	Does the wraparound plan include strategies for helping the child get involved with activities in her or his community?	1.35	1.27	0.83	1.39	0.20
2.6 (Col)	Are there members of the wraparound team who do not have a role in implementing the plan?	1.80	1.78	0.57	1.78	0.14

2.7 (Col)	Does the team brainstorm many strategies to address the family's needs before selecting one?	1.85	1.84	0.49	1.83	0.14
2.8 (Ind)	Is there a crisis or safety plan that specifies what everyone must do to respond to a crisis?	1.72	1.67	0.68	1.75	0.13
2.9 (CB)	Do you feel confident that, in the event of a major crisis, the team can keep the child or youth in the community?	1.58	1.74	0.60	1.71	0.15
2.10 (FVC)	Would you say that people other than the family have higher priority than the family in designing their wraparound plan?	1.85	1.71	0.66	1.87	0.12
2.11 (CC)	During the planning process, did the team take enough time to understand the family's values and beliefs?	1.74	1.85	0.45	1.85	0.12
3.1 (FVC)	Are important decisions ever made about the child or family when they are not there?	1.70	1.77	0.58	1.88	0.10
3.2 (Ind)	When the wraparound team has a good idea for a support or service for the child, can it find the resources or figure out some way to make it happen?	1.80	1.82	0.49	1.76	0.14
3.3 (SB)	Does the wraparound team get the child involved with activities she or he likes and does well?	1.25	1.18	0.86	1.25	0.24
3.4 (NS)	Does the team find ways to increase the support the family gets from its friends and family members?	1.53	1.43	0.83	1.49	0.21
3.5 (Col)	Do the members of the team hold each another responsible for doing their part of the wraparound plan?	2.00	1.84	0.48	1.80	0.13
3.6 (NS)	Is there a friend or advocate of the child or family who actively participates on the wraparound team?	1.00	0.96	0.96	0.93	0.22
3.7 (Per)	Does the team come up with new ideas for the wraparound plan whenever the family's needs change?	1.90	1.85	0.46	1.82	0.12
3.8 (CB)	Are the services and supports in the wraparound plan difficult for the family to access?	1.84	1.72	0.61	1.64	0.12
3.9 (OB)	Does the team assign specific tasks to all team members at the end of each meeting?	1.55	1.73	0.62	1.77	0.23
3.10 (CC)	Do members of the team always use language the family can understand?	2.00	1.93	0.31	1.96	0.10

3.11 (SB)	Does the team create a positive atmosphere around successes and accomplishments at each team meeting?	1.95	1.92	0.33	1.92	0.09
3.12 (TB)	Does the team go out of its way to make sure that all team members – including friends, family, and natural supports – present ideas and participate in decision making?	1.80	1.85	0.46	1.88	0.10
3.13 (Per)	Do you think the wraparound process could be discontinued before the family is ready for it to end?	1.42	1.54	0.76	1.36	0.16
3.14 (CC)	Do all the members of the team demonstrate respect for the family?	1.90	1.94	0.30	1.90	0.09
3.15 (FVC)	Does the child or youth have the opportunity to communicate his or her own ideas when the time comes to make decisions?	1.84	1.91	0.34	1.60	0.18
4.1 (OB)	Has the team discussed a plan for how the wraparound process will end?	1.05	0.80	0.88	1.01	0.23
4.2 (NS)	Has the wraparound process helped the child develop friendships with other youth who will have a positive influence on him or her?	1.11	1.27	0.86	1.22	0.29
4.3 (OB)	Has the wraparound process helped the child to solve her or his own problems?	1.25	1.46	0.71	1.31	0.18
4.4 (Ind)	Has the team helped the child or youth prepare for major transitions?	1.60	1.50	0.78	1.64	0.22
4.5 (Per)	After formal wraparound has ended, do you think that the process will be able to be "re-started" if the youth or family needs it?	1.89	1.76	0.59	1.86	0.11
4.6 (NS)	Has the wraparound process helped the family to develop or strengthen relationships that will support them when wraparound is finished?	1.45	1.65	0.66	1.48	0.18
4.7 (CB)	Do you feel like the child and family will be able to succeed without the formal wraparound process?	1.21	1.49	0.77	1.22	0.27
4.8 (Per)	Will some members of the team be there to support the family when formal wraparound is finished?	1.47	1.68	0.65	1.62	0.19

SECTION 3: RELATIVE STRENGTHS AND AREAS FOR IMPROVEMENT

TOM and WFI Items: Relative Strengths

TOM and WFI Items: Areas for Improvement

Two Strongest Principles Overall (TOM and WFI)*

Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

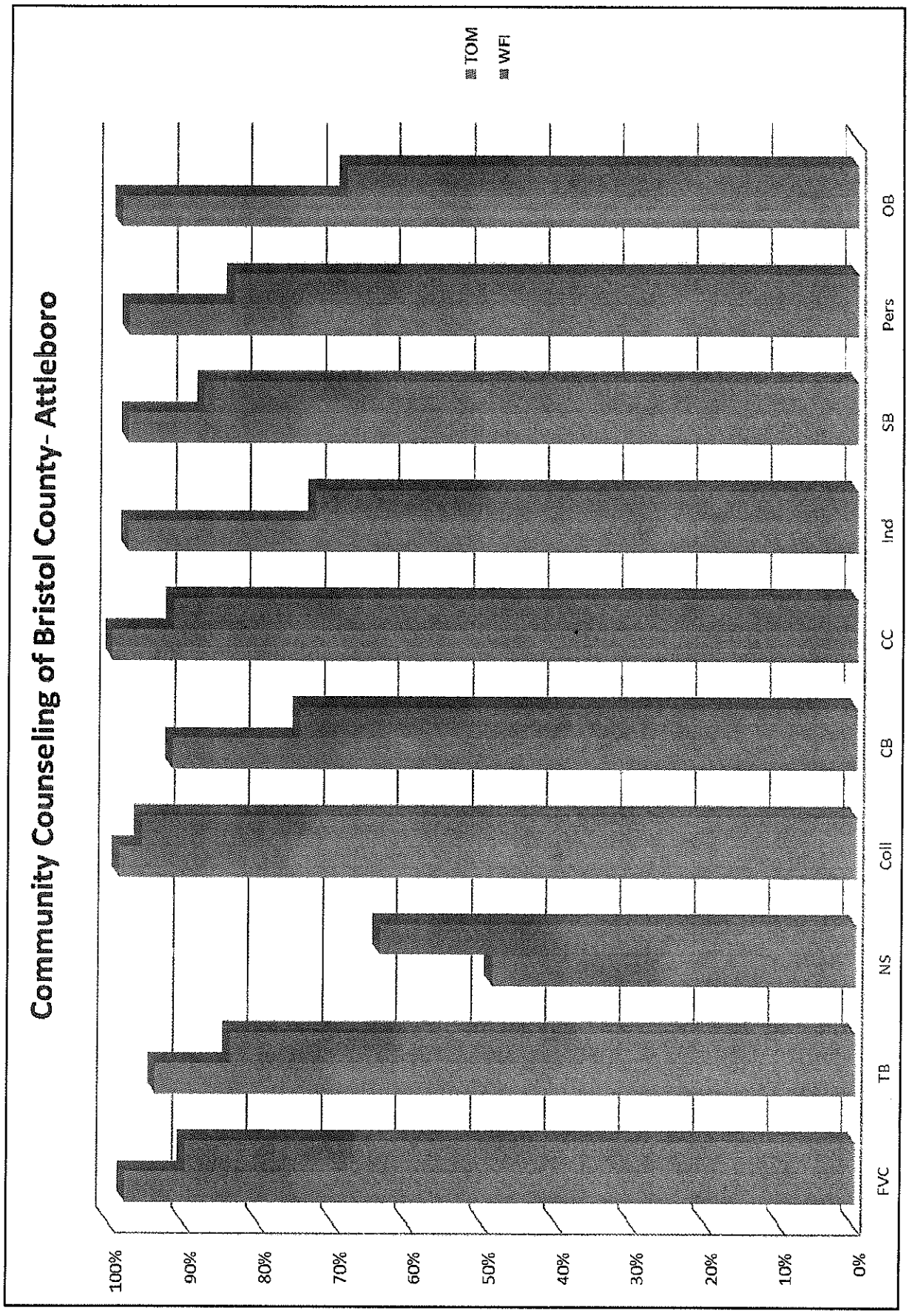
Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

Two Weakest Principles Overall (TOM and WFI)*

Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

Principle:		
CSA Score:	**State Mean:**	**National Mean:**
Description:		

* For descriptions of each principle, please see the attached *Ten Principles of the Wraparound Process* published by the NWI, Research and Training Center on Family Support and Children's Mental Health, Portland State University.


Community Counseling of Bristol County- Attleboro
TOM
WFI
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
FVC
TB
NS
Coll
CB
CC
Ind
SB
Pers
OB

[26]

TOM and WFI: Linking Principles to Items

Principle	Corresponding Items on TOM	Corresponding Items on WFI
1: Family Voice & Choice	15, 16	1.2, 2.10, 3.1, 3.15
2: Team-Based	1, 2	1.4, 1.5, 2.2, 3.12
3: Natural Supports	7, 8	3.4, 3.6, 4.2, 4.6
4: Collaboration	3, 4	2.1, 2.6, 2.7, 3.5
5: Community-Based	19, 20	2.5, 2.9, 3.8, 4.7
6: Culturally Competent	11, 12	1.1, 2.11, 3.10, 3.14
7: Individualized	5, 6	2.3, 2.8, 3.2, 4.4
8: Strengths-Based	17, 18	1.3, 2.4, 3.3, 3.11
9: Unconditional	9, 10	3.7, 3.13, 4.5, 4.8
10: Outcome-Based	13, 14	1.6, 3.9, 4.1, 4.3

3.5.3.7.1 – 3.5.3.7.2

Resumes from staff at director-level positions that have 5+ years of experience providing behavioral health services to youth and families and would be involved in MCI

Job descriptions of identified staff members who would be staffing MCI in any capacity

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **102 Program Director**

Position Title: Program Director

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: Vice President of Emergency and Diversionary Services

Summary of Position:

The Program Director (PD) is responsible for the overall operations of the ESP, including the supervision of all ESP staff and the clinical effectiveness of the program. The PD's primary function is to:

- Share responsibility with the ESP Medical Director for the clinical oversight and quality of care across ESP services.
- Responsible for the administrative and financial oversight of the ESP contract.
- Serve as primary point of accountability to MBHP and MCEs for the ESP.
- Ensure compliance with all requirements and performance specifications, including standard assessment tools, electronic encounter forms, and other data collection mechanisms.

Education/Training:

- Master's degree in Social Work or related mental health field or doctoral level.
- Must be independently licensed (LICSW, LMHC, PhD).
- Must have at least five (5) years post-graduate experience providing behavioral health services to children, families, and adults.
- Must have at least three (3) years of supervisory and/or management experience.

Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, potential safety issues, etc.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.

ESP RFR Attachment 3.5.3.7.2

- Must be able to articulate and promote a recovery-orientation that is resolution-focused, strengths-based, and culturally competent.
- Ability to manage resources, including the hiring and retention of culturally competent staff.
- Possess knowledge and practice skills regarding Continuous Quality Improvement (CQI).
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties, as well as the written skills required to manage an electronic health record system.

Responsibilities:

- Administer the recruiting and hiring process for all ESP employees.
- Develop and maintain community connections with key stakeholders
- Develop and maintain programmatic policies and procedures to support a high fidelity ESP.
- Develop and maintain the training process and protocols for all new staff.
- Provide weekly individual and group supervision to staff and conduct regular performance reviews.
- Supervise program staff, which includes providing clinical support and oversight.
- Provide monthly trainings to all program staff to ensure compliance with all agency and managed care entities mandates.
- Oversee and ensure that all managed care entities' performance specifications and medical necessity criteria are being maintained by program.
- Collaborate with community resources, local and state agencies, schools, therapists and vocational programs.
- Facilitate monthly meetings and maintain collaborative partnerships with managed care entities and various states agencies including DMH, MCI and DCF.
- Provide oversight and support to all staff in ensuring they are completing all mandated responsibilities. This includes various quality management tasks and managing any staff disciplinary issues/performance improvement efforts.
- Manages various reports needed within the program to meet Mass Health requirements
- Provides on-going support to all team members as needed.
- Provides clinical oversight to all program matters and cases.
- Assist in the development of fiscal budgets and maintain program operations within allotted budget.

List Other Job Requirements:

All staff must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.

All staff must maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren). All staff must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

ESP RFR Attachment 3.5.3.7.2

Physical Requirements:

All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance. All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **135 Direct Care/Program Staff II**

Position Title: Family Partner

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: MCI Program Manager

Education/Training:

- Bachelor's degree in human services field from an accredited university and one (1) year of experience working with the target population; **or**
- Associate's degree in a human service field from an accredited university and one (1) year of experience working with children/adolescents/transitional aged youth; **or**
- High school diploma or GED and a minimum of two (2) years working with children/adolescents/transitional aged youth.

Qualifications/Experience Requirements:

- Experience as a caregiver of a youth with serious emotional disturbance.
- Experience navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems.
- Willingness to provide mobile emergency services interventions/follow-up.

Responsibilities:

- Utilize personal and professional life experience to provide peer support to parents and caregivers served by the ESP.
- Learn the family's story, culture, strengths, and concerns.
- As requested, participate in Care Planning Team (CPT) meetings to ensure access, voice and choice within the wraparound process and to support the parent/caregiver's connection to the CPT members, as necessary.
- Serve as a bridge to ensure that family and providers understand each other's perspective and information.
- Provide a consistent source of encouragement and hope.
- Provide non-judgmental, unconditional support to parents and caregivers.
- Model effective coping techniques for parents and caregivers.
- Engage parent/caregiver in activities in the home and community.
- Assist the parent/caregiver with meeting the needs of the youth and meet one or more of the following purposes: Educating, supporting, coaching, modeling, and guiding.
- Promote parent/caregiver empowerment by including linkages to peer/parent support and self-help groups in the community.

- Teach the parent/caregiver how to identify formal and community-based resources (e.g., after-school programs, food assistance, housing resources, etc.)
- Meet weekly with an independently licensed clinician for supervision.
- Comply with all CCBC personnel policies and procedures related to employment.

List Other Job Requirements:

- Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.
- Maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren).
- Must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

Physical Requirements:

The ESP family partner provides home-based services and thus job responsibilities are often carried out in client's homes and in the community. All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **104 Supervising Professional**

Position Title: MCI Program Manager

Program Name: Mobile Crisis Intervention

Service Type: Emergency Services

Accountability: ESP Program Director

Summary of Position:

The MCI Program Manager is responsible for the overall supervision of the Clinician/Mobile Crisis Intervention Specialists and Family Partners. The MCI Program Manager maintains oversight of the program, including, but not limited, to crisis evaluation calls, evaluations, evaluation dispositions, seven-day intervention periods for youth remaining in the community, clinical appropriateness of brief solution-focused interventions, and program collaboration with collateral contacts. Data streams will include time from call to community response and location of service.

Education/Training:

- Must have at least five (5) years post-graduate experience providing behavioral health services to youth and families.
- Independently Licensed Master's Level Clinician.
- Must have at least three (3) years of supervisory and/or management experience.
- Excellent assessment and differential diagnostic skills.

Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, and potential safety issues.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.
- Must be able to articulate and promote a recovery orientation that is resolution focused, strengths-based, and culturally competent.
- Ability to manage resources including the hiring and retention of culturally competent staff.

ESP RFR Attachment 3.5.3.7.2

- Possess knowledge and practice skills regarding Continuous Quality Improvement.
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties as well as the written skills required to manage an electronic health record system.

Responsibilities:

- Weekly 1 hour supervision with Intake Supervisor and Clinical Supervisors.
- Triage consultation/supervision as needed to staff.
- Formal written tracking of supervisory sessions.
- Participation in quarterly meetings with MCEs.
- Hire and orient new staff.
- Create and maintain on-call schedule.
- Maintain ongoing relationships with MCEs and referral sources.
- Track weekly productivity of all staff and update deficits monthly.
- Track financial and referral data and provide updates to administration as requested.
- Supervise and implement disciplinary actions as needed.
- Plan annual trainings in accordance with identified core competencies and MCE training requirements.
- Supervise billing administrator and provide back-up for billing functions as needed.
- Facilitate weekly staff meeting.
- Facilitate Clinicians peer supervision meetings.
- Input all new clients and update authorizations into database system and manage error reports.
- Complete staff employee evaluations annually.

List Other Job Requirements:

Knowledge of Core-Competencies as identified by the employee's assigned department. Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

The noise level in the office / facility is usually quiet, but can be loud due to client participation and groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

ESP RFR Attachment 3.5.3.7.2

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

Signature _____ Date _____

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **104 Supervising Professional**

Position Title: MCI Clinical Supervisor

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: MCI Program Manager

Summary of Position:

Provide clinical supervision to staff, and also provide clinical services to children, adolescents, and their families.

Education/Training:

- Master's degree in a human services related discipline.
- Licensed as an LICSW, LMFT, or LMHC by the Commonwealth of Massachusetts.

Qualifications/Experience Requirements:

- Five (5) or more years of experience (post-licensure) in a human service position with at least two years of child-services-related supervisory experience.
- Must possess good organizational skills, effective written and verbal skills, and have experience with an electronic health record (EHR).
- Must possess clinical core competencies and experience regarding crisis assessment, intervention and stabilization strategies for children, adolescents, and families.
- Experience providing mobile crisis intervention services.

Responsibilities:

- Meet with individual clinicians for one-on-one supervision on a weekly basis.
- Provide impromptu supervision to clinicians in order to manage risk and client safety issues.
- Provide training/orientation for new clinicians.
- Monitor completion of client documentation and sign-off on comprehensive assessments and individualized action plans in the electronic health record.
- Review client documentation to insure that medical necessity is indicated.
- Participate in program development.
- Address clinicians' performance issues: develop performance improvement plans and manage HR issues as needed.
- Attend all required trainings.

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.
The noise level in the office / facility is usually quiet, but can be loud due to client participation in groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR):	**123 Clinician (1.0 FTE)**
Position Title:	Clinician / Mobile Crisis Intervention Specialist
Program Name:	Mobile Crisis Intervention
Service Type:	Mobile Crisis Intervention (MCI)
Accountability:	MCI Clinical Supervisor

Education/Training:

- Master's degree in human services discipline.
- Licensed as a LMHC, LCSW, or LICSW in Massachusetts.

Qualifications/Experience Requirements:

- Ability to work a flexible schedule, including nights and weekends.
- At least one year of experience working with youth and their families in a clinical role within a mobile delivery system
- Knowledge of and experience with utilizing CBHI services and the Wraparound process.
- Able to provide clinical care and support to youth and their families to prevent hospitalization and stabilize youth in the community.
- Possess a valid driver's license and reliable transportation.
- Experience with computers, specifically Electronic Health Records (EHR) systems.

Responsibilities:

- Provide brief solution-focused interventions and reassess current level of need with youth waiting for higher level of care treatment.
- Post-crisis evaluation over the course of a seven day intervention period for youth deemed appropriate to return to the community.
- Provide brief solution-focused interventions.
- Work collaboratively with family partners to provide resources/referrals, support, and psychoeducation to families.
- Attend community-based meetings in conjunction with youth, their families, and providers to assist with advocacy and addressing safety concerns.
- Complete collateral contacts with a youth's providers.
- Assist with safety planning over the course of the seven day intervention period and outside the evaluation/intervention period
- Conduct comprehensive mental health status exam for youth and adults utilizing an admissions/screening instrument which includes providing a diagnosis in accordance with the DSM V and ICB-10.

- Understanding of different treatment modalities that can be applied to stabilize clients in their home and prevent hospitalization.
- Consult with clinic director/administrator on-call and or consulting psychiatrist prior to disposition plan to include outpatient services, hospitalization, or hospital diversion.
- Participate in regularly scheduled clinical supervision, staff meetings, staff development, and training curriculum.

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

The noise level in the office / facility is usually quiet, but can be loud due to client participation in groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **105 Physician (Psychiatrist)**

Position Title: Child Psychiatry Professional

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: ESP Medical Director

Education/Training:

- An MD or DO with Board certification in psychiatry or Board Eligible; or Advanced Practicing Nurse.

Experience Requirements:

- At least five years of experience in a community crisis intervention or behavioral healthcare setting.

Responsibilities:

- Provide clinical consultation to the ESP team in assessment and crisis interventions.
- Conduct psychiatric assessments and emergency consultations.
- Consultation to hospital medical/clinical staff as required.
- Provide after hours on-call consultation and support.
- Consultation to community providers as required.
- Educate consumers and their families regarding medications / symptoms / illness / side effects.
- Provide on-site crisis assessment and management and collaborate with acute and long-term inpatient providers.
- Collaborate with other service providers as necessary (i.e., inpatient psychiatrists, primary care physicians).

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

The noise level in the office / facility is usually quiet, but can be loud due to client participation in groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

Job Description

Position (UFR): **104 Supervising Professional**

Position Title: Children's Outpatient Clinical Supervisor

Program Name: Children's Outpatient Program

Service Type: Outpatient

Accountability: Reports directly to the Vice President of Children's Services

Education/Training:

- Master's degree in a human services related discipline.
- Licensed as an LICSW, LMFT, or LMHC by the Commonwealth of Massachusetts.

Experience Requirements:

Five or more years of experience (post-licensure) in a human service position. One – two years of supervisory experience. Must possess good organizational skills, effective written, verbal, and computer skills.

Summary of Position:

Provide clinical supervision to staff, and also provide clinical services to children, adolescents, and their families. Provide administrative support to the Vice President of Children's Outpatient Services.

Responsibilities:

- Meet with individual clinicians for one-on-one supervision on a weekly basis.
- Provide impromptu supervision to clinicians in order to manage risk and client safety issues.
- Provide training/orientation for new clinicians.
- Monitor completion of client documentation and sign-off on comprehensive assessments and individualized action plans in the electronic health record.
- Mandatory attendance at Supervisors' and Children's Team Meetings. Participate in facilitating these meetings.
- Attendance at the Monthly Management Meeting.
- Review client documentation to insure that medical necessity is indicated.
- Provide Emergency Responder coverage.
- Participate in program development.
- Provide outpatient therapy to a designated number of clients per week.
- Address clinicians' performance issues: develop performance improvement plans and manage HR issues as needed.
- Attend all required trainings.

List Other Job Requirements:

Knowledge of Core-Competencies as identified by the employee's assigned department. Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

The noise level in the office / facility is usually quiet, but can be loud due to client participation in groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

_____ _____

Signature Date

D. 1.1 Proposed Program Budget

Appendix VIII ESP Cost Report

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 1 ORGANIZATION: Community Counseling of Bristol County, Inc. FY END: 6/30/2016 FEIN: 04-3035697

This schedule provides supplemental information for selected programs on an aggregated basis for use by the Commonwealth's Division of Health Care Finance and Policy in the establishment of so called "Class Rate" prices for certain Medicaid Eligible Mental Health Services. (Note that

1. UFR Program Numbers providing Mental Health Class Rate Services:

2. Program Staff and Expense Breakout by Service Component

Note: Schedule B positions not listed below are non-reimbursable for MH Class Rate services.	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE		ESP Management	
	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS
1S Program Director	1.00	62,202	0.00	0	0.00	0	0.00	0	0.00	0	1.00	62,202
2S Program Function Manager	1.00	62,202	0.00	0	0.00	0	0.00	0	1.00	62,202	0.00	0
4S Supervising Professional / QM / RM Director	0.40	22,828	0.00	0	0.00	0	0.00	0	0.00	0	0.40	22,828
4S Supervising Professional / Clinical Supervisor	1.10	62,273	0.40	22,645	0.00	0	0.70	39,628	0.00	0	0.00	0
5S Psychiatrist	0.80	177,360	0.30	66,510	0.30	66,510	0.00	0	0.20	44,340	0.00	0
7S N. Midwife, N.P., Psych N., R.N. MA	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
8S R.N. - Non Masters	1.00	62,751	0.00	0	1.00	62,751	0.00	0	0.00	0	0.00	0
9S L.P.N.	3.20	129,642	0.00	0	3.20	129,642	0.00	0	0.00	0	0.00	0
11S Occupational Therapist	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
21S Psychologist - Doctorate	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
22S Clinician-(formerly Psych.Masters)(UFR Title 12	9.70	523,164	3.00	161,803	1.50	80,902	3.50	188,770	1.70	91,688	0.00	0
23S Social Worker - L.I.C.S.W.	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
24S Social Worker - L.C.S.W., L.S.W	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
25S Licensed Counselor	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
26S Cert. Voc. Rehab. Counselor	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
28S Counselor	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ Cert Peer Spec.	1.00	44,380	1.00	44,380	0.00	0	0.00	0	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ BS and CPS	0.50	24,456	0.00	0	0.00	0	0.50	24,456	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ BS Milieu MHWI	4.20	126,616	0.00	0	4.20	126,616	0.00	0	0.00	0	0.00	0
33S Direct Care/Prog. Stf II/ Family Partner	1.70	75,446	0.00	0	0.00	0	0.00	0	1.70	75,446	0.00	0
33S Direct Care/Prog. Stf II/ Safety Staff	1.40	42,205	1.40	42,205	0.00	0	0.00	0	0.00	0	0.00	0
34S Direct Care / Prog. Staff I	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
35/36S Prog. Sec/Clerical/Maint./H-GrndsKeep.	1.30	43,550	0.50	16,750	0.30	10,050	0.00	0	0.00	0	0.50	16,750
38S Dir.Care O.T., Shift Differential & Relief	XXXXXX	0	XXXXXX		XXXXXX		XXXXXX		XXXXXX		XXXXXX	
39S **Total Direct Program Staff**	28.30	1,459,077	6.60	354,294	10.50	476,471	4.70	252,854	4.60	273,677	1.90	101,781
2E Chief Executive Officer	0.00	0										
3E Chief Financial Officer	0.00	0										
4E Acctng/Clerical/Support	0.00	0										
5E Admin Maint/House-Grndskeeping	0.00	0										
6E **Total Admin Employee FTE/Exp.**	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0
7E Commercial Products & Svs/Mkting	0.00	0										
8E **Total FTE/Salary/Wages**	28.30	1,459,077	6.60	354,294	10.50	476,471	4.70	252,854	4.60	273,677	1.90	101,781
9E Payroll Taxes 150		145,908		35,429		47,647		25,285		27,368		10,178
10E Fringe Benefits 151		204,271		49,601		66,706		35,400		38,315		14,249
11E Accrual Adjustments		0										
12E **Total Employee Compensation & Rel. Exp.**		1,809,255		439,324		590,825		313,539		339,359		126,208
13E Facility and Prog. Equip.Expenses 390		75,000		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
14E Facility & Prog. Equip. Depreciation 301		4,100		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
15E Facility Operation/Maint./Furn.390		53,200		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
16E Facility General Liability Insurance 390				XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX		XXXXXXXX
17E **Total Occupancy - Allocated**		132,300		Expense		Dollars		Dollars		Dollars		Dollars
18E Direct Care Consultant 201		0										
19E Temporary Help 202		0										
20E Clients and Caregivers Reimb./Stipends 203		0										
21E Subcontracted Direct Care 206		0										
22E Staff Training 204		10,000		2,500		2,500		2,500		2,500		
23E Staff Mileage / Travel 205		15,000						7,250		7,250		500
24E Meals 207		34,800				34,800						
25E Client Transportation 208		2,000				2,000						
26E Vehicle Expenses 208		15,000				15,000						
27E Vehicle Depreciation 208		0										
28E Incidental Medical /Medicine/Pharmacy 209		5,000				5,000						
29E Client Personal Allowances 211		0										
30E Provision Material Goods/Svs./Benefits 212		0										
31E Direct Client Wages 214		0										
32E Other Commercial Prod. & Svs. 214		0										
33E Program Supplies & Materials 215		14,000		1,400		11,200		700		700		
34E Non Charitable Expenses		0										
35E Other Expense		0										
36E **Total Other Program Expense**		95,800		3,900		70,500		10,450		10,450		500
42E Other Professional Fees 410		0										
43E Leased Office/Program Office Equip.410,390		0										
44E Office Equipment Depreciation 410		0										
48E Program Support 216		21,280		2,240		17,920		1,120				
51E **Total Direct Administrative Expense**		21,280		2,240		17,920		1,120		0		0
52E Admin (M&G) Reporting Center Allocation		205,805		41,160		133,775		15,435		15,435		
53E **Total Reimbursable Expense**		2,264,440		486,624		813,020		340,544		365,244		126,708
54E Direct State/Federal Non-Reimbursable Exp.		0										
55E Allocation of State/Fed Non-Reimbursable Exp.		0										
56E **TOTAL EXPENSE**		2,264,440		486,624		813,020		340,544		365,244		126,708

Salary	CBL	CCS	A Mob	C Mob	ESP M
62,202.14					1.00
62,202.14				1.00	
57,071.04					0.40
56,612.00	0.4		0.7		
221,700	0.30	0.30		0.20	
0	0.00	0.00		0.00	
62,751.26		1.00			
40,513.20		3.20			
53,934.40	3.00	1.50	3.50	1.70	
44,380.18	1.00				
48,911.10			0.50		
[redacted]		4.20			
44,380.18				1.70	
30,146.74	1.40				
33,500.00	0.50	0.30			0.50

DMH Southeast Emergency Services Program Privatization Analysis

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 2 ORGANIZATION: Community Counseling of Bristol County, Inc. FY END: 6/20/2106 FEIN: 04-3035697

3. Service Statistics

Total Standard Unit Hours: 3,081

	CBL	CCS	ADULT MOBILE	CHILD MOBILE
Number of Weeks Service was in Operation (e.g., 52):	52	52	52	52
Defined Unit:				
Number of Defined Units Provided:	248	977	1,276	580
Average Number of Clients in Group:	N/A	N/A	N/A	
Average Number of Staff in Group:	N/A	N/A	N/A	

CBL Units are estimated at 30% of total Child ED and Mobile units.

4. Occupancy Space Utilization

TOTAL ESP				CBL		CCS		ADULT MOBILE		CHILD MOBILE	
				Allocated Expense		Allocated Expense		Allocated Expense		Allocated Expense	
Square Ft.Used	Occupancy Total Exp.	Square Ft.Used	Allocated Expense	%	Dollars	%	Dollars	%	Dollars	%	Dollars
3,600	132,300	3,600	132,300	0.38	50,274	0.58	76,734	0.02	2,646	0.02	2,646

5. SERVICE UTILIZATION AND REVENUE BY PAYER SOURCE

	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE			
	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS
Massheallth Only (non-MCE)	0.00	0										
Massheallth MCE MBHP	1,485.00	679,132	178.00	25,632	494.00	247,000	397.00	198,500	416.00	208,000		
Massheallth MCE Fallon	4.00	2,000	0.00	0	0.00	0	4.00	2,000	0.00	0		
Massheallth MCE NHP	314.00	151,304	16.00	2,304	77.00	38,500	184.00	92,000	37.00	18,500		
Massheallth MCE Tufts-Network Health	237.00	116,720	5.00	720	33.00	16,500	187.00	93,500	12.00	6,000		
Massheallth MCE BMC Health Net	788.00	378,336	44.00	6,336	242.00	121,000	399.00	199,500	103.00	51,500		
Massheallth MCE HNE	16.00	8,000	0.00	0	11.00	5,500	5.00	2,500	0.00	0		
DMH Only	0.00	0										
Medicare/Medicaid	0.00	0										
Medicare Only	0.00	0										
Uninsured	227.00	111,720	5.00	720	110.00	55,000	100.00	50,000	12.00	6,000		
Commonwealth Care Fallon	0.00	0										
Commonwealth Care NHP	0.00	0										
Commonwealth Care Tufts-Network Health	0.00	0										
Commonwealth Care BMC Health Net	0.00	0										
Commonwealth Care Celticare/Cenpatico	0.00	0										
Health Safety Net	0.00	0										
Care Plus BMC	0.00	0										
Care Plus Fallon	0.00	0										
Care Plus NHP	0.00	0										
Care Plus HNE	0.00	0										
Care Plus Celticare	0.00	0										
Care Plus Tufts-Network Health	0.00	0										
One Care CommCare Alliance	0.00	0										
One Care Fallon	0.00	0										
One Care Tufts-Network Health	0.00	0										
Commercial Insurer	0.00	0										
Commercial with MH TPL	0.00	0										
Other	0.00	0										
Total Service Utilization/Revenue	3,071.00	1,447,212	248.00	35,712	967.00	483,500	1,276.00	638,000	580.00	290,000	0.00	0

The above revenue and units are estimates given the data as presented was not sufficient to make a more accurate projection as rates are not available from most MCEs. Our projection of revenue assumes existing utilization and assumes that all interventions as noted in the Rolling Year Units April 14 to May 15 are reimbursable. For example not all CCS days may be authorized and therefore not all CCS days will be reimbursable. Also some Adult interventions may be ED follow-up of patients boarding in ED and therefore not reimbursable.

3.10 Privatization Law Assurances

Appendix X: Organizational Commitments Pursuant to Massachusetts Privatization Law

Under Massachusetts' Privatization Law (M.G.L. c. 7 §§ 52, 53, 54, and 55), a successful bidder must:

(i) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:

1. provided ESP services; and
2. were terminated as a result of DMH ceasing to provide such ESP services;

(ii) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees; the Commonwealth currently contributes 80% of the cost of health insurance DMH employees.

(iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate as determined by the state pursuant to M.G.L. c. 7 §54 (2) for those positions for which the duties are substantially similar to the duties performed by regular agency employees;

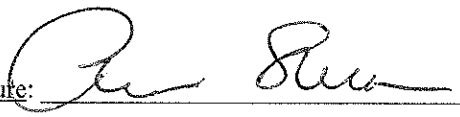
(iv) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons; and

(v) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

In addition, a successful bidder must certify in writing to the state that both the organization and its supervisory employees, while in the employ of the successful bidder, have "no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest."

Name of Organization: Community Counseling of Bristol County, Inc.

I hereby acknowledge that if the organization listed above is chosen to provide ESP services in the Southeast region of Massachusetts, the organization must implement the relevant provisions of the state's Privatization Law referenced above.

Signature: 

Name and Title (please type or print): Philip Shea, President/CEO

Date: 9/14/15

CITY OF TAUNTON
POLICE DEPARTMENT

CHIEF
EDWARD JAMES WALSH

23 SUMMER STREET
TAUNTON, MA 02780
(508) 821-1471
August 20, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street
Boston, MA 02118

To Whom It May Concern:

The Taunton Police Department has been fortunate to have a lengthy and successful working collaborative with Community Counseling of Bristol County, Inc. (CCBC). I fully support their proposal to provide a desperately needed Emergency Service Program within Taunton to support Taunton and the surrounding communities.

Police officers are often the first to deal with crisis situations involving individuals with serious mental illness or substance use disorders. In partnership with CCBC, we operate a Community Crisis Intervention Team Training and Technical Assistance Center funded by the Department of Mental Health to provide training to local police officers and service providers to better prepare them to intervene difficult and sometimes volatile situations presented by those with serious mental illness. CCBC is the sub-contractor for this award, which was recently funded for three more years, and our model has been replicated by many communities in the Commonwealth. The success of our program rests greatly on the worked performed by CCBC.

I believe that CCBC has the capacity and expertise to enhance the Emergency Service Program in our community with more timely responsiveness and greater collaboration with local health care and social service providers that would produce better outcomes for individuals receiving care.

If I can be of any further assistance, feel free to contact me at 508-821-1471x120 or via email at chief@tauntonpd.com.

Respectfully,

Edward James Walsh, Esq.
Chief of Police

Regional Chairman, Northeast
Midsized Agencies
International Association of Chiefs of Police

NORTON POLICE DEPARTMENT

82 EAST MAIN STREET
NORTON, MASSACHUSETTS 02766

BRIAN M. CLARK
CHIEF OF POLICE

ADMINISTRATIVE (508) 285-3300
ADMINISTRATIVE FAX (508) 285-3337
PATROL FAX (508) 285-3338
DETECTIVE FAX (508) 285-3339

September 1, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street
Boston, MA 02118

To Whom It May Concern:

The Community-Based location of the Taunton-Attleboro Emergency Services Program (ESP) is located in Norton, and as a result, our Department is frequently in contact with the ESP and has some understanding of the challenges they face.

As I am sure you are aware, local police officers are often the first on the scene of emergency situations involving those with serious mental illness or a substance use disorder. The Norton Police Department (NPD) has had some of their officers trained through the Taunton Community Crisis Intervention Team. This training has been applauded statewide by those that have participated. We have recently also implemented a ***Problem Oriented Policing Anti Crime Team (POP ACT)*** which will work as part of a community crisis intervention team to assist those in the community who are need of further assistance.

I understand that the Taunton Police Department has just received a three year contract to continue this service and they intend to continue the subcontract with CCBC to provide training and consultation. We are pleased that this training will continue and we look forward to having other officers receive the training.

I believe that CCBC has the capacity and expertise to enhance the Emergency Services Program in our community with more timely responsiveness and greater collaboration with local health care and social service providers that would produce better outcomes for individuals receiving care.

Please contact me if you have any questions.

Sincerely,

Brian M. Clark
Chief of Police

Attleboro Police Department
12 Union Street
Attleboro, Massachusetts 02703
Telephone: (508) 223-2224 Fax: (508) 223-2242
attleboropolice.org

Kyle P. Heagney
Chief of Police

September 3, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street
Boston, MA 02118

To Whom It May Concern:

The Attleboro Police Department is writing in support of Community Counseling of Bristol County's proposal to provide an Emergency Services Program in the Taunton/Attleboro area.

Over the past ten years the Attleboro Police Department (APD) has trained many of their officers through the Community Crisis Intervention Team in Taunton. Since its beginnings, the CCIT has partnered with CCBC for consultation and clinical leadership in the development and promotion of this jail diversion-type program. The APD has had 74 officers trained by the CCIT program, more than any other local town or city to date. I have personally participated in the training and found it to be an invaluable educational tool for officers when they are called to intervene in emergency situations with those who suffer from a mental illness and/or substance use disorder. Our long term goal is to get all APD officers trained in crisis intervention through the CCIT.

The Taunton CCIT has also mentored us as we developed a community case conference team. This monthly collaboration with other community members has been very effective in addressing pre-crisis and diversion planning for those involved with the criminal justice system. Our Problem-Oriented Policing (POP) Anti-Crime Unit has partnered with CCIT's case conference group addressing folks from Attleboro that CCBC serves. The POP unit, in partnership with CCIT, provides police and emergency service programs with assessment, respite and treatment alternatives to reduce criminalization, use of emergency rooms, and unnecessary hospitalization.

I believe that CCBC, as a facilitator of the CCIT, has the qualifications and expertise to improve the current Emergency Services Program in Taunton/Attleboro, as they continue to meet the emergent needs of the most vulnerable members of the community, and we look forward to working with them on this important endeavor.

Sincerely,

Kyle P. Heagney
Chief of Police

City Of Attleboro, Massachusetts
HEALTH DEPARTMENT
Government Center, 77 Park Street
Attleboro, Massachusetts 02703
508-223-2222 • Fax 774-203-1877

Christopher M. Quinn, M.D.
Health Officer

Alan D. Perry, REHS/RS
Health Agent

Charles E. Flanagan
Deputy Health Agent

June Fleischmann, LMHC, LADCI
Social Services

Frank Wojciechowski
Food Inspector

Jacqueline Joyal O'Brien, R.N.
Public Health Nurse

Cheryl Perry
Solid Waste Administrator

Cheryl Castro
Secretary

September 1, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street
Boston, MA 02118

To Whom It May Concern:

I am writing in support of Community Counseling of Bristol County's proposal to provide an Emergency Services Program to Taunton and the surrounding communities.

I am well acquainted with CCBC and their programs, since part of my role, as the Health Department Outreach Worker, is to support Attleboro residents under the age of 60, in identifying and accessing area and State resources which provide such basic needs, as housing, shelter, food, medical and mental health care, legal counsel, etc. Most of the people I serve are challenged by poverty, mental illness, substance abuse, medical disabilities and well as cognitive limitations. I have counted on CCBC to provide services to Attleboro residents with multiple challenges, and who often needed immediate assistance, throughout my nine years as a City Outreach Worker, and have developed collegial relationships with CCBC staff and supervisors. Also, I am a longtime member of the Greater Attleboro Taunton Coalition for the Homeless (GATCH) and have worked closely with CCBC staff members who write grants for and deliver services to the homeless in the Attleboro-Taunton area and with CCBC's Community Support Program, which provides mental health and social supports to persons who, without CSP services, would no longer be able to live, independently, in their community.

Since 2010, I have worked very closely with the Taunton Community Crisis Intervention Team, which is administered by CCBC, in collaboration with the Taunton Police Department. CCBC's Community Crisis Intervention Team endorses a community-based wraparound emergency case management approach to help stabilize persons whose mental health symptoms have negatively affected their ability to live in the community. Persons whose mental health issues are spiraling are, without intervention, likely to become involved in circumstances requiring frequent police intervention; mandatory hospitalization, followed often by non-compliance to discharge recommendations; until there is, ultimately, an arrest, prosecution, and, unproductive jail time. The provision of emergency services, in a timely manner, has diverted many Attleboro families from the

unnecessary additional emotional, social and financial hardship associated with incarceration. The CCIT's focus is on how to deliver essential safety, medical, and psychological quickly and efficiently, by offering both a forum and format for mental health and substance abuse provider, hospital case managers, police, City governmental departments (such as Health, Veterans, the Council on Aging) to develop and deliver a case management plan. Kathy Lalor and other Community Counseling of Bristol County staff, who serve on Taunton's CCIT, have made themselves immediately and consistently available to Attleboro's CCIT members, to evaluate emergent crises, as well as to support, share, and mentor the Attleboro CCIT in its efforts to provide grass roots support and crucial services.

CCBC is considered to be an "umbrella" agency, which has the capacity to provide multiple essential services to diverse populations of clients at extreme risk. CCBC willingly collaborates with other social service agencies, non-profit service agencies, police and other first responders, and community governmental departments, to assure that those among us, who are most vulnerable receive emergency and follow-up treatment. I believe Community Counseling of Bristol County is optimally qualified and suited to provide an Emergency Service Program to the residents of Taunton and surrounding communities and appreciate this opportunity to support CCBC in this proposal.

Sincerely,

June E. Fleischmann

June E. Fleischmann, LMHC, LADCI
Outreach Worker for the Attleboro Health Department

Morton Hospital
A STEWARD FAMILY HOSPITAL

Steward

September 11, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118

Dear Sir, or Madam:

On behalf of the leadership team at Morton Hospital, I am pleased to submit this letter of support regarding Community Counseling of Bristol County's (CCBC) proposal to manage the oversight of Mass Health-insured crisis patients in our greater Taunton community.

As part of Steward Health Care's System's (Steward) integrated community care model, Morton Hospital works closely with local co munity based providers to coordinate care for the ever-growing population of patients with behavioral health and substance abuse issues in the greater Taunton area. We strive to ensure that such patients have access to the services, treatment and support programs they need in order to achieve better health and wellbeing. Our region is currently the only state-run crisis team; however, we strongly believe that coordination of care through a local organization would benefit patients with behavioral health in our area.

CCBC has been delivering community-based mental health, addiction treatment and rehabilitation services for more than 40 years. Their track record of continuously demonstrating best practices in the field of mental health and addiction treatment, combined with their plethora of trained specialists and centrally-based resources, make them an ideal agency to lead this important initiative – ensuring that patients in our community receive the compassionate, specialized care they need, close to home.

We strongly support CCBC's efforts and look forward to partnering with them to best meet the behavioral health needs of our community.

Sincerely,

Kim Bassett, RN, BSN, MBA
President

STURDY
MEMORIAL HOSPITAL

September 10, 2015

Philip Shea, MBA
President/CEO
Community Counselling of Bristol County, Inc.
One Washington Street
Taunton, MA 02780

Dear Phil,

It was a pleasure meeting with you and your colleagues on Wednesday. We were very interested in hearing about the services you provide. From your description it sounds like the services you have been able to provide in the Taunton area have had a positive impact. Although those services are currently less available in the Attleboro area, it is very exciting to hear about the potential of expanding those services in this community as well.

As promised, I did alert the clinicians currently doing evaluations in the Sturdy ED of the services you provide and have verified their awareness and intent to refer whenever indicated. Historically these referrals have been predicated on service availability and insurance requirements. We are all hopeful that with the potential of your expanded presence in the Attleboro area the referral process and services provided would only improve.

We have spoken internally within our department and other leadership regarding our meeting and your request to send a letter of endorsement to MBHP. We would certainly be very pleased and more than willing to work collaboratively with you and your team if CCBC is awarded the contract to provide mental health & substance abuse services in the Attleboro-Taunton area. Your goals are closely aligned with ours and we too look forward to improving the care for those with behavioral health needs in our community.

That said, we do not feel we have adequate knowledge within the mental health arena and sufficient experiences with private vendors to endorse any particular agency. For these reasons we feel it is in our best interest to remain neutral in the selection process. We feel it is in the community's best interest for the mental health experts charged with properly vetting each proposal to select the best agency to provide those services.

We wish you luck in acquiring the contract.

Sincerely,

Maureen L. Metters, MS, RN
Director, Emergency & Ambulatory Services

Brian B. Patel, MD, FACEP
Chief, Emergency Services

Manet Community Health Center

2 Granite Avenue, Suite 101
Milton, MA 02186
T - 617-690-6400
F- 617-690-6902

1193 Sea St.
Quincy, MA 02169
T (617) 471-8683
F (617) 773-1625

180 George Washington Blvd.
Hull, MA 02045
T (781) 925-4550
F (781) 925-5052

110 West Squantum Street
North Quincy, MA 02171
T- 617-376-3000
T- 857-403-0820
F – 617-376-3036

9 Bicknell St.
Quincy, MA 02169
T (617) 471-4715
F (617) 472-4977

One Washington St., Suite 900
Mill River Professional Center
Taunton, MA 02780
T (508) 822-5500
F (508) 822-5501

August 20, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street
Boston, MA 02118

To Whom It May Concern:

Manet is a federally qualified health center dedicated to providing primary care and supportive services to all patients regardless of their financial circumstances or health insurance coverage, with three locations in Quincy, one in Hull and one in Taunton. Manet has been serving the community for over 35 years.

Manet's service area is comprised of two parts: eleven towns from which Manet currently draws most (81.8%) of its patients – Quincy, Braintree, Cohasset, Hanover, Hingham, Hull, Marshfield, Norwell, Pembroke, Scituate, Weymouth; **and five towns forming the New Access Point service area – Attleboro, Middleborough, Norton, Raynham, and Taunton**.

Manet's location in Taunton location opened in March 2014, and Community Counseling of Bristol County, Inc. (CCBC) reached out and extended fellowship and hospitality and they have serve as our behavioral health care partner caring for our patients with behavioral health needs. Manet staff frequently refers to CCBC's outpatient service and we are pleased with their rapid same day availability to those referred. Manet staff is also pleased with the care coordination and case management services that are available to our patients with serious mental illness, addictions and co-morbid serious health conditions.

Manet looks forward to adding additional primary care providers in Taunton and we are pleased to have CCBC as a behavioral partner in Taunton and look forward to working more closely with CCBC to improve the coordination of care between primary care and behavioral healthcare.

I understand that CCBC plans to submit a proposal to provide Emergency Service to your organization. I support CCBC's proposal to provide these services in Taunton and believe that this would strengthen the local health care delivery system and improve care to some of our most vulnerable patients.

Please contact me if you have any questions.

Yours truly,

Cynthia H. Sierra, M.A.
Acting Chief Executive Officer

TAUNTON PUBLIC SCHOOLS

215 Harris Street
Taunton, Massachusetts 02780
Tel. (508) 821-1100
Fax (508) 821-1177

Dr. Julie Hackett
Superintendent of Schools

Dr. Christopher Scully
Assistant Superintendent for
Curriculum and Instruction

John J. Cabral
Assistant Superintendent for
Finance and Operations

Academic excellence for every student, in every classroom, in every school.

August 20, 2015

Massachusetts Behavioral Health Partnership
1000 Washington Street
Boston, MA 02118

To Whom It May Concern:

The Taunton Public School District (TPSD) has a long history of working closely with Community Counseling of Bristol County, Inc. (CCBC) toward improving the wellbeing of children and families in our community. For the past twenty years CCBC has operated a large school based counseling program that provides access to critical mental health service for over 500 students and their families, many of whom would likely be unable to access care without school based services. This and other services CCBC provides add immeasurably to the capacity of the TPS to meet the educational needs of our students.

In addition to providing school based counseling to hundreds of children and their families we have also used CCBC's services to conduct urgent care assessment of students who might pose a safety risk to themselves or others in the school community. We were pleased by both the timeliness with which CCBC responded and the thoroughness of their assessment. Not only have we found these assessments to be timely and thorough but the availability of child psychiatrists to provide consultation around these often complex and difficult situations is a critical resource on which our teachers and administration rely.

I understand that CCBC is submitting a proposal to you to provide emergency psychiatric services in the greater Taunton area. Based upon our experience CCBC has the capacity to provide this important service and in doing so develop a more responsive, flexible and stable Emergency Service Program. The TPS fully supports CCBC's proposal and we would be eager to work with them to build this service and ensure its success in our community.

Please contact me if you have any questions.

Sincerely,

Julie Hackett

Julie Hackett, Ed.D.
Superintendent of Schools
Taunton Public Schools
508.821.1201

City of Taunton
Department of Human Services

DEPARTMENT OF HUMAN SERVICES
30 OLNEY STREET
TAUNTON, MASSACHUSETTS 02780
Telephone (508) 821-1420
Fax (508) 821-1444

ANNE C. BISSON
DIRECTOR

COUNCIL ON AGING
30 OLNEY STREET
TAUNTON, MASSACHUSETTS 02780
Telephone (508) 821-1425
Fax (508) 821-1444

September 10, 2015

Dear Massachusetts Behavioral Health Partnership:

On behalf of the City of Taunton Department of Human Services/Taunton Council on Aging (DHS/TCOA), I am writing this letter of support for the application of Community Counseling of Bristol County, Inc., (CCBC) to serve as the Emergency Services Provider for the Taunton/Attleboro area. The DHS has collaborated with CCBC on many projects and grants for over thirty (30) years, including, but not limited to, elder mental health services, substance abuse prevention and intervention services, including the Taunton Opiate Task Force, crisis intervention training, homeless services, youth programming, and the Taunton Safe Neighborhood Initiative.

CCBC maintains a strong and well-deserved reputation as a collaborative partner in the effort to serve those with mental health issues. For example, CCBC and the DHS/TCOA have worked collaboratively on elder mental health programming since the early 1980's providing the community with much needed in-home crisis services. This program was the first of its kind in the Commonwealth and continues to be a leader in elder mental health services.

CCBC also is a leader in providing the coordination of the Community Crisis Intervention Teams. The Adult, Youth and Elder Teams provide a much needed and much respected service in the community by addressing crises using a team approach on an individual basis. The Teams have trained other communities in Massachusetts and throughout the country on this model.

CCBC has been a leader in mental health services for several decades. I look forward to the vision and innovations we know CCBC will bring to the role of the Emergency Services Provider for the Taunton/Attleboro area.

Sincerely,

Anne C. Bisson

Anne C. Bisson
Director

Emergency Services Program (ESP)

Proposal Scoring Guide

September 2015

Questions included in Prescreening (no score attached)

The ESP Procurement Team will pre-screen all proposals to ensure basic requirements are met and to identify any potential disqualifications, before they are disseminated to reviewers.

All Response Submission requirements will be prescreened, such as the page limits, margin and font size, submission deadline, letter of intent submitted by deadline, etc. Reviewers will not review the proposal against the response submission requirements and these sections will not be assigned any points.

Standard high/medium/low (H/M/L/N) guidelines

The Standard H/M/L/N Guidelines should be used by all reviewers when scoring a response to a given question. For some questions, additional H/M/L/N guidelines have been added that are specific to scoring of that question.

High score for question:

- Reflects the current ESP model
- Response is specific and detailed
- Evidence that the provider "gets" model, and has clear understanding of the goals
- Requested competence is demonstrated, and supported by evidence
- Organization has addressed the provision of services to all age groups
- All components of the request are present and complete
- There is full integration of components into model
- Response reflects a comprehensive system of care
- Provides rationale and clear intentions when asked to do so
- Core competencies are comprehensive and reflect the goals of the model and the performance specifications
- All of the essential components are reflected in the bidder's program description, philosophy and/or culture
- Response includes robust data that provides evidence that the provider has the requested capability which is fully integrated into their program
- Bidder demonstrates a clear understanding of recovery principles and has integrated them fully into the program model with specific examples
- Recovery oriented terminology is used appropriately in the response

Medium score for question:

- All components of the request are present but not complete, or some components of request are not addressed sufficiently to ensure provider has clear understanding of all components of the service.
- Bidder conveys fair understanding of the goals of the ESP model.
- Evidence is supplied that demonstrates at least partial competence in the requested areas
- Some integration of components into larger model, but lacks sense of comprehensive program
- Provides intention for a service, but is vague about rationale
- Organization has addressed provision of services to only some age groups but acknowledges need to serve all age groups
- There is evidence that the core competencies reflect expectations or that the competence does not cross over all disciplines; steps to strengthen the core competencies are reflected in the plan
- Bidder's program description effectively addresses several, but not all of the components and/or values requested
- Response includes some data, but that data is not robust and does not provide evidence of the requested capability or integration of the requested component into the larger program
- Bidder demonstrates a fair understanding of recovery principles and shows some integration with the program model; specifics not present

Low score for question:

- Response not completely clear but attempts to answer question
- Unclear on intentions or rationale
- No evidence of requested competence within organization although expresses sound plan for acquiring competence through recruitment, training, subcontracting, or other means.
- Organization only addressed the provision of services to some age groups; the need to serve all age groups has not been acknowledged
- Program description only sparsely describes the program philosophy, culture, service delivery model and flow of services; description minimally addresses most of the essential components of the program
- Bidder answers question but does not include any supporting data or data provided is not relevant to the response.

Not Met

- Bidder does not convey an understanding of the ESP model
- Response does not reflect a value in seeking services that may provide a safe and alternative to more restrictive settings.
- Bidder's response indicates a poor understanding of recovery principles and recovery oriented practice
- Evidence of the requested component(s) is not provided, is insufficient, or not "on-point".
- Program description does not describe the program philosophy, culture, service delivery model and flow of services; description fails to adequately address most of the essential components of the program
- Response does not answer the question asked in the RFR or no response at all.
- No integration of components into larger model
- Bidder does not have adequate resources to support program
- Bidder will not be fully operational within 90 days of award

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
1.1 Licensure: 1.1.1 Licensed as an outpatient mental health clinic by the Department of Public Health (DPH) ☐ Yes ☐ No	Included in prescreen; No points attached		
1.1.2 Licensed as a hospital 1.1.2.1 by the DPH ☐ Yes ☐ No	Included in prescreen; No points attached		
1.1.2.2 by the Department of Mental Health (DMH) ☐ Yes ☐ No	Included in prescreen; No points attached		
1.2 Accreditation: 1.2.1 Accredited by a national organization ☐ Yes ☐ No 1.2.2 If yes, please list accreditation(s).	No points attached.	Please list accreditation(s), if applicable.	
1.3 Currently contracted MassHealth provider: ☐ Yes ☐ No	Included in prescreen; No points attached		
1.4 At least three years experience providing behavioral health services to a wide range of populations: ☐ Yes ☐ No	Included in prescreen; No points attached		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
1.4.1 Number of years providing behavioral health services) to children, adolescents, and families: _____ 1.4.1.1 Number of youth served in CY14: _____ 1.4.2 Number of years providing behavioral health services to adults: _____ 1.4.2.1 Number of adults served in CY14: _____ 1.4.3 Briefly describe the behavioral health services your organization has provided and the populations to which your organization has provided these services.	*Notes to reviewer:* *If this organization was part of a merger, the years of experience of both merged agencies may be counted, ie; if one was in business for 20 years, one for 10 years, and it has been 2 years since the merger- consider them as having 20 years experience.* ***3 possible points for 1.4.1.1-1.4.1.3 combined:*** **High (3 points)** Has provided a wide range of behavioral health services to a substantial number of people of all ages for 20+ years **Med (2 points)** Has provided a moderate range of behavioral health services to most age groups for 10 years or more or a wide range of behavioral health services to most age groups for less than 20 years. **Low (1 point)** Has provided a limited scope of service to one or more of the specified age groups for 5 years or more, or has provided a moderate range of behavioral health services to one or more of the specified age groups for less than 10 years. **Not Met (0 points)** Has less than 5 years of experience providing service to one or more of the specified age groups.		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
1.5 Presence in and knowledge of the catchment area for which your organization is applying for an ESP contract 1.5.1 Please complete the questions below regarding your current physical location within the catchment area for which your organization is applying for an ESP contract. 1.5.1.1 Number of years in which your organization operated an uninterrupted physical location at which you have provided direct services within the proposed catchment area	***2 possible points for 1.5.1.1*** **High (2 points)** An established physical location within the catchment area for a minimum of one year prior to 8/10/15. **Med (1 point)** A physical location within the catchment area for less than one year prior to 8/10/15. **Low (0.5 points)** A physical location in a contiguous catchment area for a minimum of one year prior to 8/10/15 **Not Met (0 points)** No physical location in catchment area or contiguous to catchment area for at least one year prior to 8/10/15		
1.5.1.2 Address of location meeting the above criteria, where your organization has operated for the longest duration	No points attached, but bidder must include address	Reviewer- check one: ___ address meeting above criteria is provided ___ address meeting above criteria is not provided	
1.5.1.3 If your organization does not already have a physical location in the catchment area where you would like to be an ESP, include a detailed plan for how your organization shall successfully	***2 possible points*** **High (2 points)** Organization already has physical location in catchment area identified for ESP or comprehensive, realistic plan including efforts already underway		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
establish a physical location in the catchment area within ninety (90) days of the contract award and a strong rationale as to why you wish to operate in the catchment area.	**Med (1 point)** No physical location identified but, reasonable plan with some detail but not comprehensive, minimal efforts currently underway to identify location **Low (0.5) points)** Vague plan to establish a location upon award of contract with unclear possibility of success within 90 days of contract award. **Not Met (0 points)** No plan, or unrealistic plan which is unlikely to meet expectation of 90 day start-up period.		
1.5.2 Provide a brief assessment of the proposed catchment area's needs and resources, particularly the local community's crisis continuum and its strengths and limitations, resources, barriers, gaps, and practice patterns.	***3 possible points*** **High (3 points)** Bidder's summary is a specific description of not only the unique geography, populations, and other characteristics of the community but also a specific and insightful analysis of the needs of those populations as well as the local crisis continuum and related resources, gaps, and referral/practice/utilization patterns. **Med (2 points)** Bidder's summary is a basic overview of the geography and populations but does go on to provide a fair to good analysis of the needs of the populations and the local crisis continuum and related resources, gaps, and referral/practice/utilization patterns. **Low (1 point)** Bidder's summary is a basic overview of the geography and populations but with minimal analysis of the needs of the		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	populations and/or the local crisis continuum and related resources, gaps, and referral/practice/utilization patterns. **Not Met (0 points)** Bidder's summary does not reflect understanding of the local community's crisis continuum, strengths, limitations, resources, barriers, gaps, and practice/utilization patterns; Bidder does not provide analysis specific to the geography and populations in the catchment area.		
1.5.3 Briefly describe your organization's established relationships with stakeholders in the catchment area and how they strengthen your ability to be effective as the potential ESP provider therein.	***3 possible points*** **High (3 points)** Bidder describes a considerable number of established relationships with key stakeholders across the catchment area who refer to or are otherwise involved in ESP services, or if new to the catchment area, describes specific plans for developing them with some initial steps taken. Bidder is strategic about how specific relationships strengthen, or will strengthen, their ability to be effective in providing ESP services. **Med (2 points)** Bidder describes a few relationships with key stakeholders who refer to or are otherwise involved in ESP services, or if new to the catchment area, describes some plans for developing them; and, bidder is able to articulate to some extent how these relationships strengthen, or will strengthen, their		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	ability to be effective in providing ESP services. Or, bidder has a reasonable number of relationships but is not insightful about how specific relationships strengthen, or will strengthen, their ability to be effective in providing ESP services. **Low (1 point)** Bidder describes few or no established relationships with key stakeholders who refer to or are otherwise involved in ESP services or if new to the catchment area, does not describe specific plans for developing them and has not taken initial steps to begin to develop them. If any are identified, bidder does not articulate how specific relationships strengthen, or will strengthen, their ability to be effective in providing ESP services. **Not Met (0 points)** Bidder has no relationships with key stakeholders in the catchment area and no sound strategy to develop relationships.		
1.5.4 Explain how your organization interfaces with the existing crisis program in this catchment area and supports interventions that are community-based, resolution-focused and that promote community tenure.	**3 possible points** **High (3 points**) Response includes clear example(s) of interface with crisis programs in the catchment area and details bidder's role in supporting community based, resolution-focused interventions **Med (2 points)** Response identifies general interactions, no specific example of interface with crisis program in the catchment area, touches on support for community-based,		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	resolution focused interventions that promote community tenure but no detailed experience. **Low (1 point)** Minimal or no interface with existing crisis program in the catchment area but demonstrates efforts to support interventions that are community-based, resolution-focused, and promote community tenure. **Not Met (0 points**) No interface with existing crisis programs in the catchment area, unable to articulate understanding of necessity for community-based, resolution focused intervention that promote community tenure.		
1.6 Continuum of care: Briefly describe the continuum of care operated by your organization and how you would utilize all the resources of your organization to strengthen your ESP, meet the stated goals of ESP and this procurement, and benefit the individuals and families served.	***2 possible points*** **High (2 points)** Response identifies continuum of care of more than 5 different levels of care and states how these resources will support and strengthen ESP and benefit individuals and families served by ESP **Med (1 point)** Response identifies continuum of care of 3-5 different levels of care and states how these resources will support and strengthen ESP, and benefit individuals and families served by ESP. **Low (0.5 points)** Response identifies 2 different levels of care and/or minimally states how these resources will support and strengthen ESP and benefit individuals and families served by ESP. **Not Met (0 points)** Provider currently offers 0 or		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	1 level of care, or does not adequately state how the bidder's resources will support and strengthen the ESP, and benefit individuals and families served by the ESP.		
1.7 Administrative infrastructure: Identify key staff positions within your organization and other infrastructure elements that will enable your organization to provide administrative and financial oversight and management of an ESP contract and service delivery system.	*Notes to Reviewer:* *ESP includes the following positions:* • *ESP Director* • *ESP Medical Director* • *Clinical Supervisor* • *Triage clinicians* • *Clinicians* • *Psychiatry* • *Psychiatric consultation (after hours)* *Mention of other resources to be shared with larger program/entity is fine and often encouraged for efficiency, such as the role their agency's CEO, CFO, billing staff, etc. will play in managing their ESP program.* ***2 possible points*** **High (2 points)** Identifies key positions within organization (in addition to core ESP positions) that will oversee and support the ESP (administratively and financially) with explanation of each position and how they will oversee and support ESP.		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Med (1 point) Identifies key positions that will oversee and support the ESP (administratively and financially) but does not provide description of how each position will oversee and support the ESP **Low (0.5 points)** Vaguely responds without identifying actual positions (vs. departments), does not provide explanation of how they will support the ESP, or only references core ESP positions and no other administrative or financial oversight within organization **Not Met (0 points)** Does not provide any information about positions or departments within the agency that will support ESP administratively and financially, including core ESP positions.		
1.8 Medical and clinical infrastructure: Identify key staff positions and other infrastructure elements that will enable your organization to provide medical and clinical oversight and management of an ESP contract and service delivery system.	*Note to reviewer:* *Must include positions noted above and may include other positions in ESP and/or agency.* ***2 possible points*** **High (2 points)** Includes comprehensive list of key staff (including core staff positions listed above and additional resources within organization) and infrastructure elements and describes how each will provide medical, clinical, and/or managerial oversight of ESP. **Med (1 point)** Includes some, but not all core		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	staffing positions listed above or does not include descriptions of how each position will provide medical, clinical, and/or managerial oversight of ESP, **Low (0.5 points)** Some or all Core Staffing positions listed above included, but no position designated to provide one or more of the following - medical, clinical or managerial oversight of ESP **Not Met (0 points)** No core staffing positions included, no positions designated to provide one or more of the following – medical, clinical or managerial oversight of ESP		
1.9 Quality Management (QM) infrastructure 1.9.1 Identify key staff positions and other infrastructure elements that will enable your organization to provide quality management and risk management of an ESP contract and service delivery system.	*Note to reviewer:* *Must include ESP QM Director* ***2 possible points*** **High (2 points)** Identified 1 or more key staff positions and infrastructure elements within the organization to support QM and RM within ESP Program **Med (1 point)** Either staff position(s) or infrastructure in place but not both; outlines plan to have in place prior to implementation. **Low (0.5 points)** No staff position or infrastructure in place but commitment with plan to have in place by start of contract **Not Met (0 points)** No key staff position or		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	infrastructure and no clear plan to have in place upon implementation.		
1.9.2 Required attachment: your organization's current QM plan	*Note to Reviewer:* *Locate required attachment: QM Plan and base the score on your evaluation of the QM Plan.* ***2 possible points*** **High (2 points)** Detailed <u>current</u> QM Plan attached with identified data collection methods, measurable goals, responsible parties and status updates (if indicated). QM plan appears to cover relevant quality issues. **Med (1 point)** Curren**t** QM plan attached but missing one or more features above, or QM plan requires updating but possesses all required elements, and covers relevant quality issues. **Low (0.5 points)** Current QM plan attached but goals appear unattainable, irrelevant or unclear. **Not Met (0 points)** No QM plan attached or plan requires updating/revision due to outdated, unattainable, irrelevant or unclear goals.		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
1.9.3 Briefly describe how your organization employs quality management tools and strategies to measure, monitor, and continuously improve quality of clinical care and service delivery. (If this is adequately described in your QM plan, please indicate that here. An additional summary is then not necessary.)	*Note to Reviewer: Base your review and score based on one or both of the following: what is written in the narrative in response to this question and in the attached QM plan* ***2 possible points*** **High (2 points)** Organization has clear Quality Management policies/processes and demonstrates active application and utilization; Measuring, monitoring, and improving quality of clinical care and service delivery is evident. **Med (1 point)** Organization has Quality Management processes but no evidence of utilization to improve quality of clinical care. **Low (0.5 points)** Organization Quality Management policies/processes are not current or clearly documented, minimal evidence of activities related to Quality Management. **Not Met (0 points)** No quality Management policies/processes or activities included.		
1.9.4 Provide specific examples how you shall use data and information, such as those identified in Section C.4 and C.5 below, to ensure and continuously improve the quality of ESP services and the performance of the ESP contract.	***2 possible points*** **High (2 points)** Clear examples of current or projected utilization of data reports and other information to improve quality and performance of ESP services. **Med (1 point)** Identifies specific data reports but		

1 General qualifications and infrastructure *(Possible 30 pts.)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	unable to correlate how it will be utilized in context of improving quality and performance of ESP services. **Low (0.5 points)** Reference to general data, but no reference to specific data to improve quality and performance of ESP services. Has understanding of importance of data, but minimal articulation of utilization to ensure continuous quality improvement. **Not Met (0 points**) No specific or general reference to data, or lacks understanding of importance of data and how to utilize to ensure and continuously improve quality of ESP services		
		(Possible 30 pts.) Section 1 Total	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.1 Crisis services 2.1.1 Please describe the experience your agency has had with providing crisis intervention services, including the specific services, clinical competencies, populations, payers, and durations of your organization's operation of such services.	***3 possible points*** **High (3 points)** Bidder has 15 or more years of experience in providing behavioral health crisis services to broad populations and payer sources, and may have experience in providing other types of crisis intervention as well. Bidders response is comprehensive and covers all points referenced in question. **Med (2 point)** Bidder has 15 or more years experience in providing behavioral health crisis services to a broad population and payer sources and may have experience in providing other types of crisis intervention as well. Bidder's response is adequate, but shows deficiencies in one or more area. **Low (1 point)** Bidder has 5 or more years experience in providing behavioral health crisis services to at least a limited population and public payer sources. Bidder response does not include data or documentation that demonstrates competence. **Not Met (0 points)** Bidder has less than 5 years experience in providing behavioral health crisis services to at least a limited population and public payer sources.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.1.2 Please describe the extent to which you have been successful in delivering services requiring crisis or rapid response. Include responses to the following items as well as attachments as needed: 2.1.2.1 Data and other information about your experience in meeting 24/7/365 response time requirements in an crisis environment and the specific strategies you shall utilize to do so as an ESP provider	*Note to reviewer:* *Consider whether or not data is provided, how successful bidder has been in meeting time requirements, and how specific their strategies are for meeting response time going forward.* ***3 possible points*** **High (3 points)** Provides relevant data and information that demonstrates solid strategies to meet requirement of 24/7/365 provision of services. **Med (2 points)** Submits some relevant data and information but does not have explicit strategy to ensure 24/7/365 provision of services. **Low (1 point)** Data or information submitted is vague or not specific to meeting ESP 24/7/365 response time requirements **Not Met (0 points)** No data or information provided and/or strategy to ensure 24/7/365 provision of services is not clear, relevant or realistic.		
2.1.2.2 Data and other information about your experience and efficiencies in providing telephonic crisis support, triaging, dispatching, and managing resources to respond quickly to fluctuations in demand in a	*Note to reviewer:* *Consider whether or not data is provided, how successful bidder has been in triaging, dispatching, and managing resources flexibly, and how specific their strategies are for meeting these needs and functions going*		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
crisis environment, across multiple venues, and the specific strategies you shall utilize to do so as an ESP provider	*forward.* ***2 possible points*** **High (2 points)** Provides relevant data and other information and demonstrates thorough understanding of provision of all aspects of providing emergency services in timely fashion, regardless of demand fluctuations, across multiple venues **Med (1 point)** Provides some data and information with some strategy to provide emergency services in timely fashion regardless of demand fluctuations, across multiple venues, but does not address all aspects. **Low (0.5 points)** Provides minimal data, and does not demonstrate clear strategy to provide emergency services in timely fashion regardless of demand fluctuations, across multiple venues. **Not Met (0 points)** Includes no data and/or does not have a realistic strategy that addresses provision of most aspects of emergency services in timely fashion and/or does not address demand fluctuations and/or multiple venues.		
2.1.2.3 Data and other information about your experience in hiring,	***2 possible points*** **High (2 points**) Provides data, information		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
developing, and retaining staff who are competent at providing services in an emergency environment, preferably in a behavioral health crisis intervention role, are skilled at risk management, and are able to operate in an independent and self-directed fashion, and the specific strategies you shall utilize to do so as an ESP provider.	including criteria and processes to ensure hiring and retention of competent staff who will comprise the ESP. **Med (1 point)** Provides data and information about general agency criteria and processes to ensure hiring and retention of competent staff, but not specific to ESP. **Low (0.5 points)** Minimal data and/or information about hiring criteria and processes to ensure hiring and retention of competent staff within agency or specific to ESP **Not Met (0 points)** No data and/or information about hiring criteria and processes to ensure hiring and retention of competent staff within agency or ESP specific.		
2.2 Mobile services 2.2.1 Please describe the experience your organization has had with providing services on a "mobile" basis in individuals' homes and other natural settings in the community, including the specific service, population, and duration of your organization's operation of such services.	***3 possible points*** **High (3 points)** Has been providing extensive ESP/MCI mobile services in community settings, including private homes to both children and adults for more than 5 years. **Med (2 points)** Has been providing extensive mobile services (non-ESP/MCI) in community settings, including private homes, to children and adults for more than 5 years, **Low (1 point**) Has more than 2 years providing some mobile services in community settings, including private homes, but only to a specific age group or population.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Not Met (0 points) Has less than 2 years (including none), or does not specify number of years of experience providing any mobile services in community settings, including private homes.		
2.2.2 Please describe specific strategies you have used and/or plan to use as an ESP provider to establish a culture among your staff and within your community that values the provision of mobile services in the community as the primary and preferred service delivery model.	***4 possible points*** **High (4 points)** Has successfully implemented strategies to establish a culture that values and practices mobile services in community as primary, preferred service delivery model. **Med (2.5 points)** Has taken some measures to establish culture that values mobile services in community, but still in process of transition to the model. **Low (1 point)** Identifies strategies but has not impacted culture or practices (yet) to provide mobile services in community as the primary, preferred service delivery model. **Not Met (0 points)** Has no sound strategies in place to create culture that values community based mobile services as the primary, preferred service model.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.2.3 Please describe the challenges you anticipate in establishing a culture and practice of prioritizing mobile services and specific strategies you have and/or shall use to mitigate these challenges to ensure program goals are met.	***3 possible points*** **High (3 points)** Has successfully implemented strategies to establish a culture that values and practices mobile services in community as primary, preferred service delivery model. Identifies strategies to address future challenges. **Med (2 points)** Describes challenges and sound strategies to establish culture of prioritizing mobile services but has not been fully successful yet **Low (1 point)** Articulates challenges in establishing a culture and practice of prioritizing mobile services, but strategies are vague, general, or unrealistic. **Not Met (0 points)** Does not clearly articulate challenges or strategies to establish culture of prioritizing mobile services.		
2.2.4 Please describe the experience of your organization with working with and collaborating with the community behavioral health system for children, adolescents, and families including Children's Behavioral Health Initiative (CBHI) services.	***3 possible points*** **High (3 points)** Substantial experience working and collaborating with CBHI services with clear examples included. **Med (2 points)** Some experience working and collaborating with CBHI services. **Low (1) point)** Minimal experience working and collaborating with CBHI, but demonstrates understanding of CBHI services.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Not Met (0 points) No experience working and collaborating with CBHI services and/or little or no understanding of CBHI services.		
2.3 Diversion **2.3.1 ED diversion** 2.3.1.1 Please describe your organization's experience in achieving diversions from hospital emergency departments (EDs). Include data and the specific strategies you have employed.	***3 possible point*** **High (3 point)** Bidder demonstrates they have already been embracing a vision that most BH crises can be effectively addressed in the community. Their commitment is evident in past experience, initiative and success in realizing ED diversions in their existing programs. Bidder has supported their statements with data. **Med (2 points)** Bidder shows some experience in serving individuals in BH crisis in the community rather than directing individuals to the ED, and demonstrates that, in their current practice, they have already taken some responsibility for impacting utilization patterns and diverting consumers from the ED. **Low (1 point)** Bidder provides general response endorsing philosophy of serving individuals in BH crisis in the community, identifies strategies		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	to increase community based responses vs ED, but has no data to demonstrate current practice. **Not Met (0 points)** Bidder does not show experience in achieving ED diversions and does not include any data or sound strategy to demonstrate this.		
2.3.1.2 Please describe how you shall create a culture within your organization and community that embraces the vision that most behavioral health crises can be effectively addressed in the community rather than in the hospital ED setting.	***3 possible points*** **High (3 points)** Bidder believes that intervening in BH crisis in the community is the preferred practice. Bidder sees themselves as impacting referral and utilization practices. Bidder is thoughtful and specific about strategies they (will) employ to change the culture in their organizations and/or communities around diverting BH utilization away from EDs, and they have already begun to do so. **Med (2 points)** Bidder has some insight and plans relative to how to change the culture in their organizations and/or communities around effectively addressing crises in the community. **Low (1 point)** Bidder is vague or has very general ideas regarding strategies to impact provider culture and community's acceptance of ED diversions, but not able to articulate specific actions to achieve real change. **Not Met (0 points)** Bidder's model is focused on services in the ED. Bidder does not seem to		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	embrace a vision that most BH crises can be effectively addressed in the community. Bidder seems helpless and hopeless about impacting referral and utilization practices. Bidder does not seem to think about the community based location and the mobile teams as useful alternatives and tools to achieve ED diversions.		
2.3.1.3 Please delineate specific strategies you shall implement to shift behavioral health utilization from the EDs in the proposed catchment area to community-based alternatives including the services and venues outlined in the ESP model described in this RFR. Address strategies for specific populations and stakeholders with whom you shall collaborate to achieve this goal.	***3 possible points*** **High (3 points)** Bidder is able to articulate specific, proactive, and creative strategies for doing so, including the use of the community based location and the mobile teams as useful alternatives and tools. Provides strategies for specific populations and collaborations with stakeholders. **Med (2 points)** Bidder sees the community based location and the mobile teams as alternatives and tools to achieve this goal but does not provide clear, creative strategies for doing so. **Low (1 point)** Bidder is not thoughtful or specific about strategies they will employ to change the culture in their organizations and/or communities around diverting BH utilization away from EDs. **Not Met (0 points)** Bidder has no strategies to engage specific populations and collaborate		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	with stakeholders to achieve this goal, or strategy has narrow focus that does not include more than one specific population or stakeholder. .		
2.3.1.4 Please describe the challenges you anticipate in establishing a culture and practice of shifting behavioral health utilization from hospital EDs and specific strategies you have and/or shall use to mitigate these challenges to ensure program goals are met.	***3 possible points*** **High (3 points)** Bidder is insightful and realistic about anticipating challenges and they are able to articulate specific strategies for mitigation in their commitment to achieving ED diversions. **Med (2 points)** Bidder has given some thought about challenges and has some strategies identified for mitigation. **Low (1 point)** Bidder's has some general ideas about establishing a culture and practice of shifting ED utilization to community, but strategies are vague and lack specificity. **Not Met (0 points)** Bidder is not insightful or realistic about anticipating challenges and/or not able to articulate specific strategies for addressing or demonstrating a commitment to achieving ED diversions. Bidder minimizes challenges.		
2.3.2 ED-specific plans related to ED diversion and timely response 2.3.2.1 For each hospital ED in the proposed catchment area, attach a specific plan for how your organization shall collaborate with the hospital to achieve the goals	*Notes to reviewer:* *Refer to RFR Appendix I: RSP Catchment Areas for list of all Hospital EDs within catchment area. Determine if the bidder has attached a plan for each ED or included these plans in the narrative response. Determine if the bidder has included affiliation agreements or letters from*		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
related to ED diversion and ensure timely response when individuals do present in that setting. Please indicate the status of your negotiations with each hospital relative to these plans. If you have already developed a formal agreement with any hospitals, please attach those agreements. In each attached hospital-specific plan.	*the EDs that confirm the plans they are describing.* ***3 possible points:*** **High (3 points)** Bidder attaches a plan, or includes a comprehensive individualized plan in the narrative, for each hospital ED within the catchment area. Bidder includes evidence, such as affiliation agreements or letters from hospitals; they have already talked with each ED specifically about how they will work together **Med (2 points)** Bidder indicates they have talked to each ED already about their collaboration in the redesigned system but do not include affiliation agreements or letters from the hospitals. They do differentiate opportunities among the EDs – not a "cookie cutter" response. **Low (1 point)** Bidder provides at least a couple sentences about how they'll work with each ED but there is no evidence that the bidder has talked to the EDs already about how they'll collaborate and no affiliation agreements or letters are attached. They don't say much more than that they have met with the EDs in the past and/or will meet with them in the future. Or, responses are "cookie cutter" and are not distinct for each facility.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Not Met (0 points) Bidder fails to include a plan for each ED in the catchment area, or plans are inadequate.		
In each attached hospital-specific plan: 2.3.2.1.1 Please describe how you shall work with the hospital in an ongoing, collaborative, and integrated fashion.	***2 possible points*** **High (2 points)** Bidder's plans show that they have developed strategies specific to each ED for how they will work with them in an ongoing, collaborative and integrated fashion. Strategies do not include just the fact that they will meet with the ED. They can articulate, and have already talked with each ED specifically about how they will work together. **Med (1 point)** Bidder's plans provide some specifics about how they will work with the ED, (i.e. identify key ED personnel/roles); focus more on initial collaboration rather than ongoing. **Low (0.5 points)** Bidder does not say much more than the fact that they will meet with the EDs and may not be as strong relative to a collaborative tone. **Not Met (0 points)** Bidder does not include specifics for each hospital in catchment area and/or does not set a very collaborative tone and/or does not identify specific strategies.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
In each attached hospital-specific plan: 2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served by that hospital, and the community serviced by that hospital--for how you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP's alternative community-based settings and services.	***2 possible points*** **High (2 points)** Bidder's plans are specific about how they'll get the ED to partner with them to divert volume from the ED, and the plans differ somewhat from ED to ED based on the population, community, hospital, etc. Bidder refers to how they'll use their mobile teams and Community Based location in this effort. **Med (1 point)** Bidder's plans include some specific thinking about ways they'll divert volume from the EDs, may not vary much from ED to ED **Low (0.5 points)** Bidder endorses need to work with hospital and other stakeholders to divert from ED to ESP's community based setting and attempts to identify some strategies but they are vague and non-specific. **Not Met (0 points)** Bidder's plans minimally addresses diverting volume from the ED, with little detail, do not identify how they'll use their mobile teams or Community Based location in this effort, and/or do not vary at all from ED to ED.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.3.2.1.3 Describe how you will minimize the need for ED "boarding" and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.	***3 possible points*** **High (3 points)** Response is creative, includes interventions aimed at crisis resolution, diversion, re-assessment with openness about changing dispositions based on presentation changes, identifying resources to support individual/family during and post-crisis, strong collaboration and communication with ED staff. Has solid understanding about barriers that prevent admission to inpatient and diversionary levels of care and ideas to address barriers. **Med (2 points)** Understands the boarding issues, and identifies some strategies to minimize boarding, but is not creative in finding alternate resolutions or putting resources in place while individual is boarding. **Low (1 point)** Provides standard response re: daily bed searches, "mental status updates", lack of creativity or understanding about resources ESP or other services may provide while member is boarding. Does not identify collaboration with ED beyond updates regarding status of bed search(es), **Not Met (0 points)** Does not include references to resolving crisis, arranging resources, collaboration with ED; minimal to no understanding of reasons for boarding.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. Based on historical volume, what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis, and adjust staffing to meet the need? 2.3.2.1.4.1 Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED? (e.g. designated ED). If so, please indicate which ED(s) you will enter into a subcontract with. 2.3.2.1.4.2 If yes, describe how the above will be a value-add to the crisis system of care	***4 possible points*** **High (4 points)** Does not approach response time as an indicator to satisfy funders but clearly understands how timely response indicates respect and better outcomes for the individual and family. Has a clear plan to monitor compliance in addition to reviewing MBHP data, and has sufficient back-up plan to adjust staffing to meet need on ongoing basis. **Med (2.5 points**) Provides reasonable plan to ensure ESP responds as quickly as possible, and adjust staffing as needed, but vague or unclear reference of the importance of timely response in relation to quality of care for individuals and families. **Low (1 point)** Minimal plan to monitor timely response compliance, and/or adjust staffing on ongoing basis; Will rely on MBHP data - no mention of the importance of timely response as it relates to quality care. **Not Met (0 points)** Unable to articulate a plan to ensure reasonable response time, relate to quality of care, and/or ability to adjust staffing based on need, on ongoing basis.		
2.3.3 Diversion from unnecessary psychiatric hospitalization and other out-of-home placement 2.3.3.1 Please describe your	***2 possible points*** **High (2 points)** Provides substantial data/examples of diversions from avoidable		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
organization's experience in collaborating with individuals in crisis in developing alternatives to avoidable psychiatric hospitalizations and other out-of-home placements.	hospitalizations and out-of-home placements. Includes providing/arranging resources to support individual/family in community; Includes respectful collaborations with individuals. **Med (1 point)** Provides some data/examples of diversion from avoidable hospitalizations and out-of home placements; Cursory reference to collaboration with individuals. **Low (0.5 points)** Little data or few examples of organization experience in collaborating with individuals to develop alternatives to avoidable psychiatric hospitalizations and other out-of-home placements, but appears to understand the benefits for the individual. **Not Met (0 points)** No relevant data or examples and/or lack of understanding of how to collaborate with individual to develop alternatives to avoidable psych hospitalizations and other out-of-home placement.		
2.3.3.2 Please describe how you shall create a culture and educate others in your organization and community, including families, stakeholders in hospital EDs, state agencies, and others, to foster acceptance of community-based alternatives rather than defaulting to inpatient psychiatric care.	***2 possible point*** **High (2 points)** Bidder shows a high diversion rate with clear goal of increasing community-based services. Bidder has a clear educational plan working with internal and external stakeholders to address the culture shift. **Med (1 point)** Bidder shows clear understanding of and commitment to		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	alternatives to inpatient care, however does not have a clear plan for how to operationalize. **Low (0.5 points)** Bidder theoretically expresses support, but does not demonstrate clear understanding of community based alternatives to inpatient care; no sound plan for educating internally within organization and/or externally in community. **Not Met (0 points)** Bidder minimizes needs for diversion. Bidder does not have a developed plan to increase diversions. Bidder does not address educational needs and does not understand impact of hospital based evaluations on likelihood of inpatient care.		
2.3.3.3 Please delineate specific strategies and resources you shall leverage in order to maximize the use of diversionary services as alternatives to inpatient psychiatric care and other out-of-home placement.	***1 possible point*** *Use Standard H/M/L Guidelines* **High (1 points)** Demonstrates thorough understanding of <u>all</u> diversionary services; documents benefit of diversionary services vs inpatient; detailed strategy to maximize use of diversionary services. **Med (0.5 point)**Some understanding of <u>most</u> diversionary services and usefulness to individuals, but strategy to maximize use is not specific, **Low (0.25 points)** Some understanding of <u>some</u> diversionary services but no articulation of		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	benefits to members and strategy to maximize usage is lacking in detail. **Not Met (0 points**) Little knowledge of actual diversionary services and/or benefits to individuals, no specific or sound strategies to maximize usage.		
2.3.3.4 If implementing a "designated ED" model, explain how you will ensure this happens if individuals are seen in the designated ED	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response –		
2.4 Recovery-oriented services ***Responses to this category of questions will be scored only by a designated subject matter expert; Review committee should not score questions highlighted in blue.*** **2.4.1 Hiring practices** 2.4.1.1 Please describe your organization's experience in recruiting and hiring personnel who are recovery-oriented in their beliefs.	***1 possible point*** **High (1 point)** Bidder demonstrates understanding of recovery principles including how this is integrated into hiring practices with specific strategies. Recruitment and hiring strategies include terminology that is recovery-oriented and the process mirrors that experience. **Med (0.5 points)** Bidder reports some experience in recruiting and hiring recovery-oriented personnel; articulates benefits of doing so, and describes steps already taken to implement the practice.. **Low (0.25 points)** Bidder reports commitment	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	to recruiting and hiring recovery-oriented personnel, however is vague regarding details or specifics and cannot demonstrate actual experience or articulate the added value brought by staff with lived experience. **Not Met (0 points)** Bidder has little or no experience in hiring recovery-oriented personnel. Bidder's response indicates a poor understanding of recovery-oriented practice.		
2.4.1.2 Please describe specific strategies you have used and/or plan to use to recruit recovery-oriented personnel specifically in your ESP program.	***1 possible point*** **High (1 point)** Bidder's recruitment strategy includes details around how to target people with recovery –oriented philosophy; Bidder includes sample job description(s) or identifies the terminology they use (when describing their organization as well as the qualifications for the position); Bidder identifies specific training or educational requirements they seek that would suggest a person has some knowledge of and/or experience working in a recovery-oriented environment. **Med (0.5 points)** Bidder articulates the desired personal and professional characteristics of a staff person in the ESP setting, e.g. active listener, respectful, nonjudgmental, educator, collaborative problem solver; however is not specific regarding strategies.	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Low (0.25 points) Bidder expresses commitment to philosophy and may have taken some steps to become knowledgeable, but does not have a sound strategy to recruit recovery-oriented personnel. **Not Met (0 points)** Bidder does not have an adequate understanding of recovery-oriented practice and/or does not prioritize this need. Bidder does not identify opportunities in this area.		
2.4.2 Integration of peers and family members 2.4.2.1 Describe how your organization's commitment to recovery-oriented services is and/or shall be reflected in areas such as board membership, committee membership, and organizational policies and procedures.	***2 possible points*** **High (2 points)** Bidder details the steps taken to recruit consumers/family members for the Board of Directors/Committees; Bidder identifies challenges in this area and the steps taken to address these challenges as well as their outcomes; Bidder lists the % of board members/committee members that are consumers/family members. Bidder details strategies for recruiting consumers/family members for board of directors; Bidder has consumers/family members on the board of directors; Bidder has an advisory council that includes consumers/family members- specifics around length of time the council has been in place as well as their success in recruiting and retaining consumers/family members involved	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	with the committee(s); Bidder's organizational policies include language reflective of recovery-oriented philosophy and ideas. **Med (1 point)** Bidder has a plan to put a council into place, but no specifics. Board reflects minimal representation from consumer and family voice. **Low (0.5 points)** Bidder is in early stages of acquiring knowledge and has rudimentary understanding how to operationalize/integrate into all aspects of organization. **Not Met (0 points)** Bidder does not have a detailed plan for how to incorporate a commitment to recovery-oriented services. Organizational policies, procedures, and culture indicate a sense of hierarchy and does not integrate recovery principles.		
2.4.2.2 Please describe your organization's current and planned use of peers and family members in consultative, training and service delivery capacities.	***3 possible points*** **High (3 points)** Bidder identifies past and current use of consumers/family members to assist the organization, and identifies the realized or perceived benefit; Bidder applies this experience to a clear plan to utilize consumers/family members in specific capacities with an expectation of benefit to the organization. Peer and family members' roles are not limited.	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Med (2 points) Bidder identifies past or current use of consumers or family members in particular service areas of the organization, but is not consistent among all services areas. **Low (1 point)** Bidder does not identify past or current use of consumers/or family members. Bidder identifies a plan for future use, however is limited in their understanding of all aspects of the peer and family members' roles in terms of consultation, training, and service delivery. **Not Met (0 points)** Bidder does not identify an adequate plan for involvement of peers and family members. Bidder expresses a sense of hierarchy between clinically trained staff, peers, and family members.		
2.4.2.2.1 Include specific strategies and implementation plans you shall employ to hire and integrate Certified Peer Specialists and Family Partners into your ESP staffing and services including the specific role and functions of Certified Peer Specialists and Family Partners. Address how you shall ensure that these staff members have access to peer supervision in an ongoing fashion.	***3 possible points*** **High (3 points)** Bidder has a job description for a peer specialist; Bidder has a plan for the number of hours dedicated to this position; Bidder identifies recruiting strategy for peer specialist/family partners; Bidder identifies number of hours dedicated to the position; Bidder identifies anticipated challenges with regard to hiring and integration of the position(s) and has plan for addressing these challenges; Bidder identifies plan for peer to peer supervision; Bidder recognizes that peers	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	must be considered equal members of the team in the crisis setting. Bidder has a plan to train staff in how to work with peers and include them as an equal member of the team. Bidder demonstrates understanding of the difference between a peer specialist and a clinician who is a peer but not functioning like a peer specialist, e.g. sharing personal recovery experience. Bidder demonstrates understanding of principles contained in Transcom's Culture of Respect Statement. **Med (2 points)** Bidder has a plan to hire and integrate Certified Peer Specialists and Family Partners, however is not thorough in understanding the dynamics this may bring to the ESP program. No differentiation between a peer specialist and a clinician who is a peer but functioning in a clinician role. Some understanding of principles contained in Transcom's Culture of Respect Statement. **Low (1 point)**. Some aspects of this plan may be vague or not present, including supervision, and the culture change needed to integrate certified peer specialist and family partner roles into the team. Some reference to principles contained in Transcom's Culture of Respect Statement. **Not Met (0 points)** Bidder's plan is vague and not detailed enough to indicate understanding		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	of value added to ESP by Family Partners and Certified Peer Specialists. Peer supervision is not differentiated from that provided to clinicians and training is limited to peers only with the expectation that they conform to a traditional treatment setting.		
2.4.3 Adherence to recovery principles 2.4.3.1 List, or attach, professional development activities and trainings that your organization has provided for staff at all levels of the organization relative to resiliency, rehabilitation, and recovery within the two years prior to the due date for your RFR response.	***1 possible point*** **High (1 point)** Several specific trainings and other specific professional development activities designed to enable various levels of staff to develop knowledge and skills related to resiliency, rehab and recovery. **Med (0.5 points)** A few trainings and/or other opportunities specifically focused on enabling most agency staff to develop knowledge and skills related to resiliency, rehab and recovery, or many trainings with a component devoted to resiliency, rehab and recovery **Low (0.25 points)** Some trainings or opportunities related to resiliency, rehab and recovery but not provided to a limited number/level of staff. **Not Met (0 points)** No trainings or opportunities related to resiliency, rehab and recovery	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.4.3.2 Please describe how your organization ensures and/or plans to ensure integration of recovery principles into practice, including those listed in Section II.B Core Competencies, under "recovery oriented treatment" and Section II.C Clinical Competencies under "recovery-promoting treatment approach."	***2 possible points*** **High (2 points)** Bidder demonstrates a track record for integrating recovery principles into practice in emergency services and/or other programs. Bidder articulates specific, proactive strategies for integrating recovery principles throughout all service components in their proposed program model. Bidder references the core competencies delineated in the RFR, such as commitment to consumer choice, consumer completed advance directives, natural supports, etc. Bidder demonstrates a commitment to reduction and elimination of restraint and seclusion as well as an understanding of alternatives to restraint and seclusion, e.g. creation of specific, individualized plans containing alternative activities that sooth, calm and deescalate. **Med (1 point)** Bidder shows some evidence of experience in integrating recovery principles into practice within emergency services and/or other programs. Bidder has given some thought to how they will integrate recovery principles into their ESP program model. Bidder may make some reference to the core competencies delineated in the RFR, such as commitment to consumer choice, consumer completed advance directives, natural	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	supports, etc. **Low (0.5 points)** Bidder has recently embraced recovery principles and is in early stages of integration into organization; commitment to incorporating recovery principles into ESP culture. .Bidder makes some reference to core competencies delineated in RFR. **Not Met (0 points)** Bidder shows no evidence of experience in integrating recovery principles into practice within emergency services and/or other programs. Bidder does not seem to embrace a vision of how recovery principles can be implemented in a crisis services environment, and may minimize or even reject the need to do so. Bidder shows little or no thought about how they will integrate recovery principles into their proposed program model. Bidder does not make reference to the core competencies delineated in the RFR or any other specific recovery principles		
2.4.3.3 Please describe the challenges, if any, you anticipate in shifting fully to a recovery-orientation and specific strategies you shall utilize to mitigate those challenges to ensure program goals are met.	***1 possible point*** **High (1 point)** Bidder's response demonstrates ongoing success in shifting to a recovery-orientation within their organization and articulates specific challenges they faced in shifting fully to a recovery orientation as well as strategies they will utilize in ESP to mitigate them in order to achieve the vision of a	Score by Nan Donald	

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	recovery oriented emergency services program. Bidder identifies systemic and structural process to address recovery orientation at the executive level. Bidder recognizes that untrained clinical staff may be likely to treat peers like junior members with less knowledge and a less valuable contribution. Bidder recognizes the challenges of balancing safety and recovery principles in a crisis setting and articulates specific strategies regarding the principles of shared risk and shared responsibility, active dialogues about shared risks between staff and consumers. **Med (0.5 points)** Response demonstrates some success in shifting to a recovery orientation in various "pockets" of the organization and identifies challenges to agency-wide shift. Has detailed plans to continue process including specifics pertaining to ESP. **Low (0.25 points)** Bidder is somewhat thoughtful and realistic about challenges they anticipate in shifting to a recovery orientation and may have some initial plans for how they will mitigate them. **Not Met (0 points)** Bidder is not thoughtful and realistic about challenges they anticipate in shifting to a recovery orientation and has no plans for how they will mitigate them. Hierarchy remains strong with a lack of		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	perspective about recovery and peer workers. Peer or family members' work is confined and not seen as an agency opportunity.		
2.5 Culturally competent services 2.5.1 Population and related experience 2.5.1.1 Describe the racial, ethnic, cultural, and linguistic composition of the population in the catchment area for which your organization is applying for an ESP contract.	***1 possible point*** **High (1 point)** Bidder identifies a thorough understanding of cultural diversity and the needs of the community. Description includes race, ethnicity, culture, language, faith, gender, and socioeconomic status. **Med (0.5 points)** Bidder identifies understanding of cultural diversity of the community but does not explore needs of the various populations. **Low (0.25 points)** Bidder exhibits understanding of certain facets of cultural competency/diversity (i.e. discusses race and ethnicity, but not culture, linguistic, socioeconomic). **Not Met (0 points)** Bidder does not reflect understanding of the cultural diversity or needs of the community.		
2.5.1.2 Document your organization's experience in providing services to the cultural and linguistic populations in the proposed catchment area, including data.	***1 possible point*** **High (1 point)** Bidder describes experience in providing services to aforementioned cultural and linguistic populations. This understanding is evidenced by data and source of data is noted.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Med (0.5 points) Bidder describes experience with providing services to diverse populations reflective of the catchment area, however may leave gaps in a thorough understanding of the community or does not include any relevant supporting data. **Low (0.25 points)** Bidder has experience providing cultural and linguistic services in other programs/geographic areas that does not necessarily match the specific cultural diversity of the proposed catchment area. **Not Met (0 points)** Bidder does not show experience with the cultural and linguistic population of the catchment area, or outside the catchment area, or the view of cultural competency is limited and lacking in meeting the needs of the population.		
2.5.1.3 Describe any culturally and linguistically tailored program models that you currently operate. Describe the degree to which the staff and management of these programs reflect the cultural and linguistic populations served.	***1 possible point*** **High (1 point)** Bidder has developed and implemented successful program models that are tailored to the population in their catchment area(s). Bidder staff matches the population served. **Med (0.5 points)** Bidder has a limited history of culturally and linguistically tailored program models, but has some success in recruitment/ retention of qualified staff that match the		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	population served. **Low (0.25 points)** Bidder has a limited history of culturally and linguistically tailored program models and has not been successful in attracting/retaining qualified staff to match the population served. **Not Met (0 points)** Bidder does not have programs that are tailored to meet the needs of the community. Bidder's staff does not match the population served.		
2.5.1.4 Describe your organization's current or planned efforts to engage populations your organization believes are underutilizing or not fully benefiting from ESP services in the catchment area for which your organization is applying for an ESP contract.	***1 possible point*** **High (1 point)** Bidder has developed detailed strategies to meet the needs of the community, acknowledges barriers within the system and provides specific strategies to mitigate barriers. **Med (0.5 points)** Bidder acknowledges need to engage under-served populations, identifies barriers, includes some promising ideas that require development. **Low (0.25 points)** Bidder provides vague strategies to mitigate barriers, or does not identify barriers. **Not Met (0 points)** Bidder does not have strategies developed to meet the needs of the community. Bidder minimizes the need to		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	modify services to meet the needs of the community.		
2.5.2 Organizational capacity 2.5.2.1 Describe your organization's capacity to provide culturally and linguistically competent behavioral health services to children, families, and adults including the extent to which your organization's staff and governance reflect the significant cultural and linguistic populations within the ESP service area as well as your efforts to ensure that all staff members develop cultural competence. Address:			
2.5.2.1.1 current composition of governance and senior management relative to this issue;	***1 possible point*** **High (1 point)** Bidder has diverse representation among board members, management, and staff that reflect the significant cultural and linguistic composition of the catchment area. Bidder has developed strategies to match the cultural needs of the community in leadership roles. **Med (0.5 points)** Bidder has diverse representation that reflect the demographics		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	of the communities being served by the organization (not specifically this catchment area) among board members, management, and staff. Response includes details regarding organizations effort to ensure all staff members develop cultural competence. **Low (0.25 points)** Bidder has diversity on board but it is not reflective of the cultural and linguistic composition of communities served by this organization. Agency has a sparse plan to ensure staff members develop cultural competence, across all levels of the organization. **Not Met (0 points)** Bidder staff does not reflect the community. Bidder may have staff in direct service, but not in leadership roles. Bidder does not have representation that reflects the community on any boards.		
2.5.2.1.2 any initiatives in the past two years undertaken by your organization's Board of Directors to strengthen the cultural diversity of Board and/or senior management, and the results of those efforts;	***1 possible point*** **High (1 point)** Bidder has established initiatives evident in training, development, and operations regarding culturally competent care. Bidder describes initiatives in detail including results. **Med (0.5 points)** Bidder has detailed strategies and plans, but no evidence of implementation is included (information re: number of initiatives, # of attendees, roles of attendees,		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	etc.) **Low (0.25 points)** Bidder's strategies are vague. Cultural diversity efforts are present but remain vague or not well integrated into daily operations. Inadequate or no supporting documentation. **Not Met (0 points)** Bidder does not demonstrate clear strategies relative to cultural diversity. Strategies identified do not indicate cultural diversity as a priority on the Board.		
2.5.2.1.3 the number of bilingual/bicultural staff employed by your organization and the extent to which your direct care staff reflect the significant MassHealth-enrolled cultural and linguistic populations in the proposed catchment area;	***1 possible point*** **High (1 point)** Bidder employs a high number of bilingual/bicultural staff, matching the population identified in the catchment area. **Med (0.5 points)** Bidder employs some bilingual/bicultural staff with an attempt to match the population with limited success. Bidder has strategy to increase number of staff that reflect the cultural and linguistic populations in the proposed catchment area. **Low (0.25 points)** Bidder staff does not adequately match the population in the catchment area but has documented efforts to recruit/retain, challenges faced, and sound strategies to overcome challenges. **Not Met (0 points)** Bidder staff does not		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	adequately match the population in the catchment area and has no realistic strategy to do so. Bidder does not acknowledge importance of staff reflecting the cultural and linguistic populations in the proposed catchment area.		
2.5.2.1.4 your organization's access to interpreter services for whom the organization does not currently have sufficient bilingual/bicultural staff; and	***1 possible point*** **High (1 point)** Bidder identifies languages where interpreters are needed and has established relationships with organizations to provide interpreter services in a timely fashion. **Med (0.5 points)**.Bidder acknowledges need for interpreters and is in process of exploring or establishing relationships for interpreter services. **Low (0.25 points)** Bidder acknowledges need for interpreters but does not identify specific plan to ensure interpreter access. **Not Met (0 points)** Bidder utilizes family members or non-licensed individuals to provide interpreter services. Bidder minimizes the need to communicate in the individual's language.		
2.5.2.1.5 list or attach professional development activities and trainings that your organization has provided	***1 possible point*** **High (1 point)** Bidder provides regular training		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
for staff at all levels of the organization relative to cultural competence within the two years prior to the due date for your RFR response.	to staff at all levels of the organization. Bidder has listed at least 8 diverese examples within the 2 year period. **Med (0.5 points)** Bidder has provided some training regarding cultural competence Bidder has listed between 4 and 7 diverse examples within the 2 year period. **Low (0.25 points)** Bidder provides 1-3 examples of diverse cultural competence training within the 2 year period. **Not Met (0 points)** If no specific examples of cultural competence trainings within the 2 year period, or content of all trainings focusses on one population only score should be “0”		
2.5.2.2 Describe or attach any of the following that are currently in place within your organization with regard to delivering culturally and linguistically competent care: mission statements, definitions, policies, and procedures reflecting the organization’s dedication to providing culturally competent care.	***1 possible point*** **High (1 point)** Bidder notes priority of culturally and linguistically competent care in mission statement, specific definitions, policies and procedures. Bidder has specific examples of integrating a priority of culturally and linguistically competent care. **Med (0.5 points)** Bidder notes priority of culturally and linguistically competent care; however attachments may not indicate the desired level of prioritization. **Low (0.25 points)** Bidder expresses priority of culturally and linguistically competent care in response, but does not include any		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	attachments. **Not Met (0 points)** Bidder is vague and does not attach specific examples of delivering culturally and linguistically competent care.		
2.5.2.3 Document any organizational initiatives undertaken within the past two years to strengthen cultural and linguistic competency or capacity.	***1 possible point*** **High (1 point)** Bidder describes detailed initiatives to strengthen both cultural and linguistic competency and capacity. **Med (0.5 points)** Bidder is vague, but does provide examples of attempts to strengthen cultural and linguistic competency and/or capacity. **Low (0.25 points)**.Bidder has plan for future initiatives but no evidence of any organizational initiatives undertaken within past 2 years. **Not Met (0 points)** Bidder does not indicate any organizational initiatives to improve cultural and linguistic competency nor capacity. Initiatives provided are not focused on cultural nor linguistic need, and/or bidder minimizes the need for improvement in this area		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.5.3 Describe any experience you have had in forming partnerships with minority, community-based organizations, mutual assistance agencies, or multi-service agencies for immigrants and refugees to meet the care and support needs of clients.	***1 possible point*** **High (1 point)** Bidder describes a thorough understanding of community based organizations and has formed partnerships with most of these agencies as evidenced by specific reference and letters of support. **Med (0.5 points)** Bidder includes some examples of collaboration, but no formal partnerships. **Low (0.25 points)**. Response is vague and does not indicate specifics. **Not Met (0 points)** Bidder does not describe any experience with any of these organizations or agencies.		
2.6 Other special populations: Describe your organization's experience and expertise in providing behavioral health services to the following populations, and articulate how you shall modify your program, offer specific ESP service components, and/or otherwise ensure access to ESP services for these populations as well clinically appropriate assessment and intervention.	**Note to reviewers:** All ESP staff must receive training regarding evaluations with each specific population. If the organization does not provide the services to the population currently, there should be a clear commitment and plan to do so if they receive the ESP contract.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.6.1 Elders	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.2 Veterans	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.3 Persons who are homeless	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.6.4 Persons with substance use conditions	**High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.5 Persons with co-occurring mental health and substance use conditions	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Low (0.25 points) Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.6 Persons who are deaf and hard of hearing	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.7 Persons who are blind, deaf-blind, and visually impaired	***1 possible point*** **High (1 point)** Has documented expertise in		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.8 Persons who are involved with the Department of Mental Health (DMH)	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise. .		
2.6.9 Youth and families involved with the Department of Children and Families (DCF)	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.6.10 Youth and families involved with the Department of Youth Services (DYS) and/or the juvenile court system	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.11 Youth who are on the Autism Spectrum	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		
2.6.12 Persons who are receiving services from Department of Developmental Disabilities (DDS)	***1 possible point*** **High (1 point)** Has documented expertise in successfully treating this population within existing agency services, clearly articulates how ESP staff will achieve competence to provide clinically appropriate assessment and intervention with this population. **Med (0.5 points)** Has limited experience providing services but no specialty and/or a vague plan to ensure ESP staff will work competently with this population. **Low (0.25 points)** Has limited experience providing services but no specialty, and no plan to ensure competence of ESP staff. **Not Met (0 points)** Has no experience working with this population and no credible plan or commitment to cultivate expertise.		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.7 Intersystem planning and affiliation 2.7.1 Describe your organization's experience in convening a collaborative structure to integrate services across agencies.	***1 possible point*** **High (1 point)** Bidder demonstrates a leadership role in interagency initiatives that involve multiple agencies such as task forces, grant collaborations, etc. Bidder is able to facilitate innovative collaborations that identify and address a need in the community by bringing multiple entities "to the table". **Med (0.5 points)** Bidder has been an active participant in interagency initiatives that involve multiple agencies such as task forces or grant collaborations. Believes that inter-agency collaboration generally yields positive results. **Low (0.25 points)** Bidder has some experience collaborating with other agencies, but not on a broad spectrum that will address gaps in services needed by consumers. **Not Met (0 points)** Bidder may or may not attend and does not actively participate in any interagency initiatives; Bidder tries to keep all services "in-house" rejecting collaborations that may better meet the needs of consumers.		
2.7.2 Describe what processes and structures you would utilize to collaborate with other stakeholders in implementing, monitoring, and	***2 possible points*** **High (2 points)** Bidder has an established forum for stakeholder feedback and		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
overseeing the performance of your ESP program. For example, would you establish a community advisory board, utilize a specific existing forum for obtaining feedback and recommendations about the functioning of your ESP, etc.?	collaboration with lessons learned or plans to create such a forum. Structure includes service integration, obtaining feedback, and recommendation. Forum includes representation from the community. **Med (1 point)** Bidder has plans to develop a forum for feedback, but it has not been fully implemented or requires further development. **Low (0.5 points)** Bidder has plans to develop a forum for feedback but may have deficiencies in operations. (i.e. limited stakeholder involvement, forum has too broad a focus) **Not Met (0 points)** Bidder has limited or no experience in collaboration with stakeholders with no clear plan on how to achieve.		
2.8 Please describe how your organization shall train, develop, support, and evaluate all ESP staff individually and your ESP program as a whole, both initially and on an ongoing basis, to ensure that the core competencies described in 2.1 – 2.7 are consistently implemented in all ESP service components.	***5 possible points*** **High (5 points)** Bidder articulates a plan for training that is consistent with above statements. Training is ongoing and integrated into other systems, supervision, etc. Plan is cutting edge (uses technology, webinars, training modules, competency tests, etc.) **Med (3 points)** Bidder training plan addresses most of the components, but does not have innovative initiatives to measure and assure competence for ESP staff on an ongoing basis. **Low (1 point)** Bidder includes a basic "cookie cutter" plan. Plan minimally meets the		

2 ESP core competencies *(possible 100 points)*			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	performance specification requirement, but does not reflect commitment to provide ongoing monitoring or resources available to support staff, or reflect the importance of these competencies for ESP clinicians. **Not Met (0 points)** Plan is vague, does not ensure that staff will receive initial or ongoing support and monitoring in order to perform competent assessments and interventions. Bidder may be unable to manage multiple priorities		
		(Possible 100 pts.) Section 2 Total	

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.1 Emergency Services Program (ESP): overall program 3.1.1 Provide a brief program description that summarizes your overall ESP program model addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.	***3 possible points*** **High (3 points)** Program description is specific and detailed, giving the reader a clear picture of their program model and flow, including specific descriptions of at least the required elements: philosophy and culture, service delivery model, and flow of services. **Med (2 points)** Program description gives the reader a reasonable picture of their program model and flow, including some reference to the required elements: philosophy and culture, service delivery model, and flow of services. **Low (1 point)** Program description is brief, general and vague. Does not give the reader a picture of their program model and flow. **Not Met (0 points)** If response does not include most or all of the required elements: philosophy and culture, service delivery model, and flow of services., score "0"		
3.1.2 How shall you change the perception which may exist in your organization and/or in your community that the ESP's function is to conduct "hospital screening"? What operational and cultural changes shall your organization make to ensure the delivery of ESP	***3 possible points*** **High (3 points)** Embrace the definition of ESP as a level of care including crisis assessment, intervention and stabilization and is thoughtful about the perceptual changes needed to consistently implement this level of service across all ESP service components. Articulates a		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
services that consist of a comprehensive and discrete level of care, incorporating crisis assessment, resolution-focused intervention, and stabilization?	clear vision of a program model that integrates all the required service components (adult and youth mobile, community- based location, and adult CCS) across the catchment area. Addresses strategies to modify agency culture, if applicable. **Med (2 points)** Demonstrates some understanding of the definition of ESP as a level of care including crisis assessment, intervention and stabilization and includes an assessment of the change that will be needed to implement this definition of ESP encounters. Articulates some operational and/or cultural changes the bidder will implement to ensure the consistent delivery of this definition of the level of care. **Low (1 point)** Demonstrates some understanding of the definition of ESP as a level of care including crisis assessment, intervention and stabilization but does not include an adequate assessment of perceptual change needed to implement the model successfully. **Not Met (0 points)** Does not seem to understand and/or embrace the definition of ESP as a level of care including crisis assessment, intervention and stabilization. Vague, non-specific, or non-existent assessment of perceptual change needed and/or minimizing level of perceptual change needed. Failure to articulate operational and cultural changes they will implement to ensure the consistent delivery of this definition		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	of the level of care.		
3.1.3 Describe how you shall realize the vision and manage your ESP program, inclusive of all service components, as one integrated continuum of emergency services responsible for meeting the emergency behavioral health needs throughout the proposed catchment areas.	***3 possible points*** **High (3 points)** Articulates a clear and specific plan, including substantive content with multiple do-able strategies to achieve. Bidder articulates specific proactive plans for how they will manage their program to ensure integration or CCS, adult and youth mobile, and community based location. **Med (2 points)** Some ability to envision a program model that integrates all the required service components (adult and youth mobile, community- based location, and adult CCS) and articulates some plans for how they will manage their program to ensure this integration. **Low (1 point)** Discusses integration of some components, but no clear plan and/or intent to achieve integration among all components. If utilizing subcontractor(s) for one or more components, mentions oversight of subcontractors on administrative level but does not address integration at operational level. **Not Met (0 points)** Does not seem to envision a program model that integrates all the required service components (adult and youth mobile, community- based location, and adult CCS) into one emergency services program across the		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	catchment area, and does not articulate how they will manage their program to ensure this integration.		
3.1.4 Describe how your ESP program shall operate in a fashion that ensures fluidity among its service components, including how you shall use your staff resources in an integrated and flexible manner, while accommodating fluctuations in volume, location of services, etc. Please include your strategy to address seasonal variations in volume as well as variability among shifts.	***2 possible points*** **High (2 points)** Has a clear plan to integrate the ESP service components to maximize resources; Articulates innovative strategies to address volume fluctuations **Med (1 point)** Understands and supports concept of integration of ESP resources but does not have a definite approach to implement; does not fully correlate adjustment of staffing patterns to seasonal and shift volume **Low (0.5 points)** Has minimal understanding of how to integrate to ESP components and no creative strategies to address volume variations by shift and season. **Not Met (0 points)** Assign "0" if no acknowledgement of need to integrate components and no tactics to address volume variations.		
3.1.5 Describe how your ESP's 800# and triage function shall operate, noting any variance by time of day or day of week.	***2 possible points*** **High (2 point)** Detailed description of 800# and triage function that addresses variations by time of day, day of week, season, holidays, etc. including back-up plan for unexpected fluctuations; identifies number of staff, their		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	roles, skill level, training provided, and detailed description of supervisory support that will be provided. **Med (1 point)** Response demonstrates understanding of complexity of 800 # and triage function, but does not have detailed plan, or does not adequately address variances by time of day, day of week, season, holidays, and/or includes general description of staff and supervisory structure, but no detail regarding training, roles, skill level, and/or description of actual support provided by supervisory staff. **Low (0.5 points)** Cursory description of 800 # and triage function, lacking specifics regarding plan to address variances by time of day, day of week, season, holidays, basic documentation of staff positions that will perform triage functions but little detail regarding skills required, training, and supervisory oversight. **Not Met (0 points)** Response minimizes role of 800 # and triage functions, lacks info or detail regarding plan to address variances, or plan is not adequate; does not demonstrate understanding of roles of personnel involved in triage and level of skill involved in triage function, or back-up and support needed for personnel performing triage.		
3.1.6 Describe how you shall cover the entire geography in the	***2 possible points***		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
proposed catchment area 24/7/365. Does your organization have resources, such as various locations you can leverage, as part of your strategy?	**High (2 points)** Presents a clear, detailed plan for covering entire geography in catchment area 24/7/365 with specific resources and sites already located within catchment area. If utilizing subcontractors, plan includes oversight of subcontracted services to ensure 234/7/365 provision throughout entire catchment area also. **Med (1 point)** Presents satisfactory plan to cover entire geography in catchment area 24/7/365 but few or no existing resources and/or sites located within catchment area presently. References to subcontractors (if appropriate) and has oversight plan to ensure 24/7/365 coverage throughout entire catchment area**.** **Low (0.5 points)** Expresses commitment to cover entire geography in catchment area 24/7/365, but no clear plan (or plan has many gaps) on implementation, and/or no existing resources or sites located within catchment area presently. If utilizing subcontractor(s), no clear oversight plan to ensure 24/7/345 coverage throughout entire catchment area. **Not Met (0 points**) Does not demonstrate understanding of importance of implementing coverage 24/7/365 in entire catchment area, has few or no resources or sites located within catchment area and/or restricts services to a limited portion of the catchment area or specific hours. If utilizing subcontractor, does not explain		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	oversight to ensure subcontractor provides services 24/7/365 throughout entire catchment area.		
3.1.6.1 How shall you ensure a one-hour response time, from the time of readiness for ESP intervention, throughout the proposed catchment area 24/7/365? Do you anticipate any particular challenges with meeting this requirement in any areas within that catchment area, and if so, how shall you mitigate those challenges?	***2 possible points*** **High (2 points)** Demonstrates understanding of importance of one hour response time from time of readiness for ESP intervention throughout entire catchment area, 24/7/365, as well as challenges to achievement, and includes pragmatic strategies to mitigate challenges. **Med (1 point)** Commits to ensuring a one-hour response time from time of readiness for ESP intervention throughout entire catchment area, 24/7/365, but response cursorily addresses challenges with some strategies to mitigate challenges but success is questionable**.** **Low (0.5 points)** Does not have clear plan to ensure one-hour response time from readiness for ESP intervention throughout entire catchment area 24/7/365 and minimizes challenges or provides vague or unrealistic solutions to address challenges. **Not Met (0 points)** Does not demonstrate understanding of importance of one hour response time and/or challenges to meet the requirement 24/7/365. Does not include any strategies to mitigate challenges, or strategies do		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	not address the challenges satisfactorily.		
3.1.7 While a goal of this procurement is to ensure that the implementation of the ESP model shall be substantially consistent statewide, describe and give a rationale for any variances in the service model described in this RFR that you think are indicated to accommodate local needs, preferences, and/or resources in the proposed catchment area. Include but do not limit your response to any variance from the requirements included in Section II.D.2 Community-based location, under "description."	No points attached Please use this information when evaluating responses throughout proposal regarding any modification due to local variance. **Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response –		[redacted]
3.1.8 Location of services: 3.1.8.1 Please provide general information about the planned location(s) of ESP functions and services as well as hours of operation:	***Note to reviewers:*** *Any location that has not been identified by a specific address MUST have a plan for development within 3 months of contract award Community Based Location has minimum operation of 12 hrs/day weekdays and 8 hrs/day weekends.* ***1 possible point*** **For scoring:**		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	High (1 point) Has a suitable identified location that requires minimal action (cosmetic) to be fully operational at inception of contract. Meets or exceeds required hours of operation**.** **Med (0.5 points)** Has a suitable identified location that requires some steps (renovations, relocation of existing programs, leases/purchase of property, etc.) in order to be fully operational within 3 months of contract award. Commitment to meet the required hours of operation. **Low (0.25 points)** Does not have an identified location yet, but has begun search process and states that whatever location is established will be fully operational within 3 months of contract award and commits to required hours **of** operation. **Not Met (0 points)** Has not begun search process and/or cannot commit to be fully operational within 3 months of contract award. May not be able to initially commit to the required hours of operation.		
3.1.8.2 If you intend to change locations or make substantive changes to any existing physical plants prior to service start date or within the first six months of operation, please describe those plans here.	No points attached Please use this information when evaluating responses throughout proposal regarding any m **Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.1.9 ESP management 3.1.9.1 Please attach resumes, or if not yet hired, please describe hiring qualifications of the following positions:	*Note to reviewers: Please score this question regarding resumes and/or hiring qualifications for ESP Director, QM Director, and Medical Director (as noted in 3.1.9.1.1, 3.1.9.1.2, and 3.1.9.1.3)* ***1 possible point*** **High (1 point)** Resumes and/or qualifications for all 3 positions meet MBHP performance specifications listed below. **Med (0.5 points)** Resumes and/or qualifications for 1 position does not meet MBHP performance specifications listed below. **Low (0.25 points)** Resumes and/or qualifications for 2 positions does not meet MBHP performance specifications listed below. **Not Met (0 points)** None of the resumes and/or qualifications meet the MBHP performance specifications listed below.		
3.1.9.1.1 ESP Director	*ESP Director must be Full time position must be Masters or Doctoral level licensed clinician.*		[redacted]
3.1.9.1.2 Quality/Risk Management Director	*QM Director must be Masters or Doctoral level staff person with behavioral health background, may be shared resource (does not have to be licensed clinician).*		
3.1.9.1.3 Medical Director	*Medical Director must be board-certified or board-eligible psychiatrist, may be (and will likely be) shared resource.*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.1.9.2 Attach an organization chart that indicates where these and other key ESP staff shall sit within the organization at an administrative and supervisory level.	*Required attachment – org chart* ***1 possible point*** **High (1 point)** Organization chart attached including ESP specific staff with clear reporting lines. **Med (0.5 points)** Organization chart attached but clear reporting lines not established. **Low (0.25 points)** Partial organization chart is included without clear information indicating where ESP fits into the entire agency structure. **Not Met (0 points)** No organization chart attached or organization chart does not include ESP specific staff		
3.1.10 Psychiatry: Describe your plan for psychiatry staffing and ensuring that all performance specifications related to access to adult and child psychiatric consultation and direct services, in all ESP service components, are met 24/7/365.	***2 possible points*** **High (2 points)** Detailed plan for 24/7/365 adult and child psychiatry staffing (including availability for urgent on-site psych consult/ psychopharm**),** all ESP components included**,** timely phone consultations, with many psych staff already identified. **Med (1 point)** Detailed plan for 24//365 adult and child psychiatry staffing but not adequate for one component, and/or no psych staff already identified, but includes aggressive recruitment plan. **Low (0.5 points)** Plan is general, acknowledges expectation of 24/7/365 psych coverage, but does not address actions to meet performance specifications for all components; has not		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	identified psych staff, no substantial recruitment plan. **Not Met (0 points)** Plan does not address psych coverage for some or all components in performance specifications, no identified psych staff, no substantial recruitment plan,		
3.1.11 Safety: Articulate specific strategies you plan to employ to assess, and mitigate risk during the provision of ESP services in the community-based location and adult CCS as well as through Mobile Crisis Intervention services.	***1 possible point*** **High (1 point)** Includes ongoing thoughtful strategies regarding safety while balancing with respect and dignity for consumers and families, policies do not support over-utilization of law enforcement in routine situations. Does not immediately default to ED referrals or refusals to perform interventions in community based on "buzz words" such as "suicidal", "homicidal" "does not want to be evaluated", "out-of-control" without gathering more information. Supervisors are actively involved in triage decisions. CSS and ESP work as a unit ensuring that all staff are responsible for safety in both programs. **Med (0.5 points)** Includes some strategies for staff but does not articulate importance of balancing consumer and family choice; Understands that requesting law enforcement presence at community based evaluations should not be standard practice, but vague about		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	circumstances when it is appropriate to request assistance from law enforcement. Supervisors are consulted in triage decisions. Reference to CSS and ESP staff supporting each other during emergencies, but not on ongoing basis. **Low (0.25 points)** Has a less flexible/less individualized criteria for determining whether an intervention should occur in the community vs ED and/or whether law enforcement should be involved initially. No mention of consulting Supervisors in triage decisions. No mention of relationship between CCS and ESP to ensure safety. **Not Met (0 points)** Criteria for community based evaluations is rigid, low threshold to decline and/or no on-going training or support regarding safety for ESP and/or CCS staff. Does not acknowledge perspective of family and/or consumer in individual situations. Uses law enforcement to perform "safety checks" without ESP presence as a standard tool, or tells families to contact 9-1-1 routinely Lack of understanding how escalations may occur when ESP does not work with consumer and/or family and/or utilizes law enforcement as first response.		
3.2 Community-based location 3.2.1 Describe your ESP's proposed community-based location(s)	***2 possible points*** **High (2 points)** Proposed location meets the		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
including: 3.2.1.1 General description of the physical plant, include parking, signage, entryway, waiting areas, treatment areas, meeting space, and staff work areas	needs of the community. **Med (1 point)** Proposed location is not ideal or has some deficits in meeting the needs of the community. **Low (0.5 points)** Proposed location is inadequate to meet stated goals, but plan included to meet expectation of contract within 3 months of award. **Not Met (0 points)** No proposed location and/or location is not suitable and will not meet criteria within 3 months of award.		
3.2.1.2 Data supporting the fact that the location is centrally located in a major population center within the catchment area	***1 possible point*** **High (1 point)** Location is centrally located in a major population center within the catchment area. Data and rationale for location is included. **Med (0.5 points)** Location is centrally located in a major population center within the catchment area but no supporting data. **Low (0.25 points)** Actual location has not yet been identified but commitment to being centrally located in a specific major population center within catchment area with data supporting the location included. **Not Met (0 points)** Location selected is not centrally located within major population center within catchment area and no supporting data and/or logical rationale included; or location has not been identified and no clear plan to locate in a specific major population center within		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	catchment area.		
3.2.1.3 Rationale for how this location is "in the community" and shall be perceived as such by those who utilize ESP services. 3.2.1.3.1 Optional attachment: letters of support endorsing the selected location	***1 possible point*** **High (1 point)** Rationale regarding the location of ESP being "in the community" by ESP utilizers is clear and appropriate. Letters of support from diverse sources that reflect the catchment area are attached. **Med (0.5 points)** Rationale for location may be viewed by some ESP utilizers as "in the community" but some groups of utilizers may not share that perspective. Some letters of support attached but not reflective of entire catchment area. **Low (0.25 points)** Rationale for location viewed by some groups of ESP utilizers as "in the community" but some groups of utilizers are excluded. No letters of support attached or letters of support do not address this issue. **Not Met (0 points)** Unclear rationale for location being viewed by ESP utilizers as "in the community"; no letters of support or letters of support do not address this issue.		
3.2.1.4 Proximity and access to public transportation	***1 possible point*** **High (1 point)** Detailed information regarding satisfactory proximity and access to public transportation from multiple points in catchment area, with schedule that addresses 7 days per week and/or hours of day that public		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	transportation is operational. **Med (0.5 points)** Information regarding satisfactory proximity and access to public transportation but no detail regarding availability from multiple points within catchment area or day/s hours of operation. **Low (0.25 points)** Limited proximity and access to public transportation but some satisfactory availability. **Not Met (0 points)** No satisfactory proximity and access to public transportation.		
3.2.1.5 How you shall establish a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support	***1 possible point*** **High (1 point)** Description of physical and interpersonal environment is detailed and includes all the features listed. **Med (0.5 points)** Description of physical and interpersonal environment is detailed - addresses a clear picture of some, but not all features listed. **Low (0.25 points)** Description of physical and interpersonal environment is general and does not convey a clear picture of the majority of the features listed. **Not Met (0 points)** Description does not convey a physical and interpersonal climate that is welcoming, and communicates respect, patience, compassion, calmness, comfort and support.		
3.2.1.6 How you shall concurrently communicate that this is a setting	***1 possible point*** **High (1 point)** Has comprehensive plan including		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
to receive help for crisis behavioral health needs rather than for routine services or general support and socialization	person(s) responsible, to provide broad education to referral sources as well as utilizers of ESP and CCS services distinguishing between crisis behavioral health services/prevention than routine general support and socialization. Has strategy to provide resource information to those who require general support and socialization and specifies some of those available resources. **Med (0.5 points)**. Has some strategies to provide education to referral sources and utilizers of ESP and CCS services regarding the differentiation between crisis behavioral health services/ prevention and routine general support and socialization, Plan includes developing resource guide for referrals to non-behavioral health crisis situations. **Low (0.25 points)** Plans to communicate role of ESP to referral sources and individuals, as need arises, and provide information regarding other resources to meet the needs of individuals seeing routine services, general support, and socialization when possible. **(0 points)** No clear/sound strategy or plan to educate referral sources and/or individuals regarding the role of ESP and CCS, or provide resource information for routine services, general support and socialization.		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.2.2 Describe how you shall utilize your community-based location(s) to achieve the goals of ESP and this procurement, including:	***1 possible point*** **High (1 point)** Proposal has a plan consistent with community needs, including outreach, and addressing ED diversion. **Med (0.5points)** Proposal has a plan; however there are some deficits, including after-hours dependence on ED services instead of community outreach, especially for MCI services. **Low (0.25 points)** Weak plan to utilize community based location to meet needs of community via outreach and ED diversion. **Not Met (0 points)** Proposal does not have a plan with community centered goals.		
3.2.2.1 How the selected community-based location shall support the goal of diverting behavioral health utilization from the hospital EDs in the proposed catchment area	***3 possible points*** **High (3 points)** Proposal has a plan consistent with community needs, including outreach, and addressing ED diversion. Identifies referral sources with whom to partner to increase ED diversion and collaboration with ED to increase community based interventions. **Med (2 points)** Proposal has a plan; however there are some deficits, such as default to ED services during peak periods, or does not identify community partners/ED collaborations to increase ED diversion; References MCI community based services as 24/7. **Low (1 point)** Weak plan to utilize community based location to meet needs of community via outreach and ED diversion; After-hours and/or		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	peak period dependence on ED services instead of community outreach, does not reference of provision of community based MCI services 24/7 **Not Met (0 points)** Proposal does not have a plan with community centered goals. Plan includes reliance on ED services, no community/ED partnerships to increase diversion from ED.		
3.2.3 Staffing 3.2.3.1 Describe how the staffing in your community-based location shall be used flexibly to meet the needs on a daily basis, including integration with the adult CCS.	***2 possible points*** **High (2 points)** Plan addresses flexible staffing, including shared resources, training, and foresight. **Med (1 point)** Plan addresses flexible staffing that may leave CCS or ESP inadequately staffed occasionally **Low (0.5 point)** Plan does not address flexibility between CCS and community-based location but suggests other appropriate resources. **Not Met (0 points)** If no plan to flex staff, score "0"		
3.2.3.2 Describe how you shall utilize Certified Peer Specialist staff in your ESP community-based location(s).	*Note to Reviewers: Plan MUST include role for certified peer specialist consistent with recovery principles in order to receive points in this section.* ***2 possible points*** **High (2 points)** Bidder demonstrates understanding and commitment to value added/role of Certified Peer Specialist within ESP community based location, consistent with recovery principles.	Score by Nan Donald	

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Med (1 point) Bidder shows understanding of Certified Peer Specialist role but does not address the role within ESP community based location specifically, and/or response is partially consistent with recovery principles. **Low (0.5 points)** Bidder has cursory understanding of Certified Peer Specialist role within ESP community based location, and/or lack of consistency with recovery principles. **Not Met (0 points)** Response does not reflect the role of the Certified Peer Specialist within ESP community based location that is consistent with recovery principles,		
3.3 Adult Mobile Crisis Intervention 3.3.1 Provide a brief program description that summarizes your planned Adult Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.	*Adult mobile must be provided 7am-8pm to any community based location* *Adult mobile must be provided 24/7 to residential programs and hospital EDs* ***6 possible points*** **High (6 points)** Comprehensive Program description that addresses clear priority for mobile services in the philosophy with a concrete strategy for implementation; **Med (4 points)** Plan addresses clear priority and strategy for mobile services in philosophy with gaps in addressing <u>one</u> of the following areas satisfactorily– program philosophy, culture, service delivery model, or flow of services.		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Low (2 points) Plan includes priority for mobile services, however does not address concrete strategy on how to achieve. Does not address more than one of following areas satisfactorily – program philosophy, culture, service delivery model and flow of services; **Not Met (0 points)** Plan does not demonstrate priority or preference for mobile services or does not satisfactorily address program philosophy, culture, services delivery model and flow of services in thoughtful, credible manner		
3.3.2 Describe how you shall utilize bachelor's level staff and/or Certified Peer Specialists to support the adults utilizing these services and to assist the master's level clinicians in providing ESP services to adults in a mobile capacity.	***4 possible points*** **High (4 points)** Plan includes detailed role for Bachelor's level staff and Certified Peer Specialists with specific examples to assist MA level clinicians in providing ESP services to adults in mobile capacity. **Med (2.5 points)** Plan includes detailed role of BA level staff and Certified Peer Specialist but does not provide specific examples demonstrating how exactly they will assist MA level clinicians in providing ESP services to adults in mobile capacity. **Low (1 point)** Plan summarizes role of BA level staff and Certified Peer Specialist in general terms, but does not provide level of detail that identifies how they will assist MA level clinicians in providing ESP services to adults in mobile capacity.	Score by Nan Donald	

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Not Met (0 points) Plan does not address assistance by BA level staff and/or Certified Peer Specialist staff in supporting MA level clinicians specifically in providing ESP services to adults in mobile capacity.		
3.4 Adult Community Crisis Stabilization (CCS) 3.4.1 Provide a brief program description that summarizes your planned adult CCS addressing, at a minimum, program philosophy and culture, target population, staffing pattern, service delivery mode, and flow of services.	*Note to Reviewers:* *Staffing includes:* *Nurse Manager* *Master's level clinician* *Psychiatrist* *LPN* *Bachelor's level staff (Certified Peer Specialist preferred)* *Plan includes flexibility with community-based location and goals to increase hospital diversion.* ***4 possible points*** **High (4 points)** Plan is comprehensive, thoughtful, detailed, includes flexibility within community-based location and goals to increase hospital diversion with emphasis on benefits to individuals, and clearly addresses program philosophy, culture, target population, staffing pattern, services delivery mode and flow of services. **Med (2.5 points)** Plan is comprehensive and includes goal to increase hospital diversions, but does not adequately address up to two of the		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	minimum points of program philosophy and culture, target population, staffing pattern, service delivery mode and flow of services, OR does not include benefit of CCS option for individuals, OR does not include flexibility within community-based location. **Low (1 point)** Plan correlates CCS with hospital diversions, does not sufficiently address more than two of the minimum points of program philosophy and culture, target populations, staffing pattern, service delivery mode and flow of services or flexibility within community-based location and/or does not identify benefits of CCS option for individuals. **Not Met (0 points)** Plan does not identify goals of hospital diversion, does not include clear vision of philosophy, culture, target populations, staffing patterns, service delivery mode and flow of services; does not convey understanding of purpose, benefit to individuals, or how to successfully operate a CCS program.		
3.4.2 Physical plant 3.4.2.1 General description of the adult CCS's space, including treatment areas, living space, meeting space, staff work areas, and parking	***2 possible points*** **High (2 points)** Bidder has identified a community-based, "home-like" environment, Space is detailed and designed to meet needs of individuals (i.e accessible, ability to admit clients requiring single room) Plan includes development (if needed) and concrete efforts to		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	maintain functional physical environment. **Med (1 point)** Description is detailed and descriptive of physical plant but does not address special accommodations. Includes plan to maintain functional physical environment. **Low (0.5 points)** Bidder has identified a plan for physical space, however demonstrates some deficits OR does not provide detail or operationalization. Does not adequately address capability to accommodate all adult populations (physical accessibility, individuals requiring single room) **Not Met (0 points)** Bidder has not identified detailed plan regarding both physical space and environment, but has provided superficial description of some of the characteristics of the potential CCS site.		
3.4.2.2 How you shall establish a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support	***2 possible points*** **High (2 points)** Thorough response that conveys a true commitment to a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort and support. Provides detailed examples of incorporation of these traits into every-day practices. Stresses the importance of these qualities in all aspects of program.		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Med (1 point) Response addresses the physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort and support but no examples of how program practices incorporate these traits. **Low (0.5 points)** Response pays "lip service" but does not communicate a true sense of consistent respect, patience, compassion, calmness, comfort and support in the physical environment and interpersonal climate; **Not Met (0 points)** Response does not reflect understanding of how to create a physical environment or interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort and support.		
3.4.3 State your plan related to co-location of the adult CCS with the ESP community-based location 3.4.3.1 Describe the co-located or shared space relative to proximity, flow, and any space that shall be shared for functions of both the ESP and adult CCS. 3.4.3.2 State whether co-location shall be in place at the implementation of the ESP contract.	***5 possible points*** **High (5 points)** Provides a clear, detailed plan of physical configuration of community based, co-location of ESP and CCS programs highlighting both program-specific and shared space and functions,. Both programs will be fully operational at the same location upon implementation of contract **Med (3 points)** Provides a description of the community based location that will house both ESP and CCS, but no detail of shared space and functions. If proposal does not include co-		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.4.3.3 If it will not, attach an implementation plan outlining how and when co-location shall be achieved within three months of the initiation of the contract. (Note that failure to achieve co-location within three months may result in termination of the contract.)	location of ESP and CCS, a detailed rationale for not doing so with clear description of physical spaces, proximity, and benefits for individuals accessing services. **Low (1 point)** Description of physical community based location housing CCS and ESP is not specific, may not have a location identified yet, so description represents a "wish list" more than a definite plan. If not co-locating, unable to demonstrate benefits of not co-locating. **Not Met (0 points)** Description of physical community based location housing ESP and CCS is inadequate, does not meet standards for providing respectful and safe services to individuals or description focuses entirely on one aspect of the program, instead of describing an integrated model with distinct space for specific services.		
3.4.4 If a bidder wishes to propose changes to the required minimum CCS capacity allocated to each catchment area, please describe your recommendations and related justification, including how the bidder proposes to increase the CCS capacity within the cost projections for each catchment area.	No points attached. review and make notes re if you do or don't recommend what the bidder is proposing		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.4.5 What is your proposed communication plan between your adult CCS and your other ESP service components, particularly your ESP community-based location, for example, staffing, sharing resources, transfers, sharing clinical knowledge, risk management/safety planning, joint rounds, joint staff meetings, etc.?	***3 possible points*** **High (3 points)** Bidder demonstrates understanding and has developed a communication plan between CCS and ESP services including specific strategies to foster integration within community-based location. Expresses benefits of sharing resources in terms of quality of services. **Med (2 points)** Bidder demonstrates basic understanding including possible efficiencies (budgetary benefits) but does not provide detail in plan. Bidder does emphasize that the co-location and sharing resources will enhance quality of services. **Low (1 point)** Bidder has a communication plan between CCS and ESP but it does not emphasize sharing resources, integration of services or enhanced quality of services. May articulate some budgetary benefits. **Not Met (0 points)** Bidder does not express understanding of integration of CCS and other ESP service components in relations to quality, budgetary efficiencies, etc.		
3.4.6 Describe your planned approach to utilize the full clinical potential of the adult CCS outlined in this RFR and the performance specifications. Address how shall you educate stakeholders of the	***4 possible points*** **High (4 points)** Proposal has a comprehensive plan to provide CCS services to consumers with complex issues/higher level of acuity, which addresses performance specifications and RFR expectations. Also has detailed plan to		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
capacity and acuity level of the adult CCS and how shall you make consumers, families, and other stakeholders feel comfortable using the adult CCS to treat those who present with a higher level of acuity.	communicate internally and externally, outlining specific goals and plans for operationalization. **Med (2.5 points** Proposal has a plan to provide CCS services to consumers with complex issues and higher levels of acuity, but does not specifically address performance specifications and/or RFR expectations. Communication is adequate. **Low (1 point)** Plan to provide CCS to consumers with complex issues and higher levels of acuity is lacking in some areas, and/or communication plan lacks detail. **Not Met (0 points)** Proposal does not describe plan to accept consumers with complex issues/higher acuity, or express clear understanding of successful operation of CCS. Communication plan is sparse.		
3.5 Mobile Crisis Intervention (MCI) Response Section (Note: An incomplete or unsatisfactory response to this element could exclude a bidder's proposal from consideration.) 3.5.1 Statement of intention:	*NOTE TO REVIEWERS: This section is not scored. However, the reviewer should be clear on the bidder's intentions when reviewing the elements under section 3.3.* Bidders's Intent (*reviewer*--check one) ___ The bidder intends to directly operate the Mobile Crisis Intervention component of the ESP and shall demonstrate competency in the section that follows. ___ The ESP intends to enter into a		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	subcontract arrangement with another entity that meets the requirements of subcontractors outlined in Section V.C. of this RFR. Enter the name of the agency (additional information will be requested in narrative response section 4.3. below). The competency of the proposed subcontractor agency is demonstrated in the section that follows.		
3.5.2 Provide a rationale for your organization's decision reflected in question 3.5.1 above and a brief summary of how your proposed subcontractor meets the provider qualifications for providing the subcontracted service component	*NOTE TO REVIEWERS: Bidder should accomplish <u>one</u> of the following in this section:* *1. Provide summary that indicates Bidder will demonstrate competency in 3.5.3* *2. Provide summary that indicates Bidder will demonstrate partial competency in 3.5.3 AND attach a plan for how the organization shall fully meet the criteria within three months of implementation of the ESP contract* *3. Provide summary that indicates Bidder intends to subcontract the service, identify the subcontractor that will provide the service, and demonstrate the SUBCONTRACTOR'S competency in section 3.5.3* ***2 possible points*** **High (2 points)** Bidder is clear on its intentions,		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	has made a sound case for this business decision, AND has attached a plan or identified a subcontractor if applicable, AND the plan is comprehensive in describing how the organization will fully meet the criteria within three months of award. **Med (1 point)** Bidder is clear on its intentions, AND has attached a plan or identified a subcontractor, if applicable BUT plan is not very detailed although intent is stated to fully meet the criteria within three months of award. **Low (0.5 points)** Bidder presents a plan, but it is vague or with inadequate rationale for plan and it is questionable that organization can fully meet criteria within three months of award. **Not Met (0 points)** Bidder is unclear on its intentions regarding the full scale operation of Mobile Crisis Services for youth and adults. Bidder does not supply a rationale for the decision. If selecting option 2, Bidder does not attach a plan. If selecting option 3, bidder does not identify a subcontractor. Commitment to fully meet criteria within three months of award is not credible.		
3.5.3 Further demonstrate your organization's (or proposed subcontractor's) readiness to provide Youth Mobile Crisis Intervention by attaching the	*NOTE TO REVIEWER: In section 3.5.3 Bidders are being asked to demonstrate their level of competency. They may do this by providing the documentation that is proposed in the language, providing alternative documentation or some*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
following documents (as many as are available and applicable to your organization) in order to demonstrate meeting the criteria delineated in Section V.B. of this RFR:	*combination of both.* If bidder plans to subcontract mobile crisis services, then Section 3.5.3 must demonstrate the competency of the proposed subcontractor that the bidder named in Section 3.5.1.		
3.5.3.1 Documented experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis prevention, resolution-focused crisis intervention, parental engagement and support, and/or treatment services, such as contracts for the provision of such services at various levels of care, clinical tools used to deliver effective resolution-focused intervention in collaboration with children and families, and/or data reflecting the number of children and adolescents served in the past year	*Bidder demonstrates clinical competency in providing BH services to youth and families—can be assessment, crisis or treatment services. This experience can be demonstrated in ways such as but not included to: program descriptions, service volumes, encounter data, contracts for the provision of the services, supplying youth-specific clinical tools.* ***2 possible points*** **High (2 points)** Evidence demonstrates full competency in this area. Bidder demonstrates actual and substantive experience of services to youth and families. If not the primary population, data indicates the treatment of youth/families is not an anomaly. Bidder demonstrates that interventions are designed in a way that are youth/family specific. **Med (1 point)** Evidence is supplied that demonstrates partial competence in this area by one or more of the following: parental engagement and support, existing or prior contract(s) to provide similar services to children		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	and/or adolescents, utilization of effective clinical tools, and/or data supporting ability to deliver fully competent services upon implementation **Low (0.5 points)** There is experience, but it appears that the level of service activity is very low OR there is evidence of training in this area, but no actual services are demonstrated. **Not Met (0 points)** Evidence is not supplied, is insufficient, or not on-point, no training or demonstrated expertise in providing services to youth, no clear plan to achieve competence by start of contract.		
3.5.3.2 Evidence of knowledge, commitment, and experience implementing services to children, adolescents, and families consistent with *Systems of Care* and *Wraparound* principles (refer to Section II.D of this RFR)	*NOTE TO REVIEWER: If you are not familiar with these concepts, you must review Section II.D (p. 11) of this RFR before scoring this section.* *Bidder demonstrates clinical competency in providing services that are consistent with Wraparound or other Systems of Care principles. This can be demonstrated in ways such as but not limited to the following: description of actual experience in delivering services that adhere to Wraparound or other Systems of Care principles, methods of service delivery are in keeping with these principles, training schedules/attendance rosters indicate staff are learning these principles, policies and procedures describe the use of these philosophies within the agency, the*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	language in program brochures is in keeping with these principles , position descriptions identify staff competencies that are in keeping with these principles. ***2 possible points*** **High (2 points)** Evidence demonstrates competency in this area. Bidder demonstrates actual and substantive experience in this area. **Med (1 point)** Evidence is supplied that demonstrates at least partial competence in this area. **Low (0.5 points)** there is experience, but it appears that the level of service activity is very low OR there is evidence of training in this area, but no actual services are demonstrated. **Not Met (0 points)** Evidence is not supplied, is insufficient, or not on-point.		
3.5.3.3 Evidence of competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services	*Bidder demonstrates clinical competency in partnering with youth, parents and other caregivers to achieve affective treatment engagement. This can be demonstrated in ways such as but not limited to the following: program descriptions, referral out statistics, youth/parent educational materials, assessment tools that document the engagement of youth and parents, identification of strengths and treatment preferences, and/or evidence that care and treatment planning is guided by youth and their*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	families ***2 possible points*** **High (2 points)** Evidence demonstrates competency in this area. Bidder demonstrates actual and substantive experience in this area. **Med (1 point)** Evidence is supplied that demonstrates at least partial competence in this area **Low (0.5 points)** there is experience, but it appears that the level of service activity is very low OR there is evidence of training in this area, but no actual services are demonstrated. **Not Met (0 points)** Evidence is not supplied, is insufficient, or not on-point.		
3.5.3.4 Policies, procedures, and/or clinical protocols developed specifically for the provision of behavioral health services to youth and families, including treatment strategies that differ from the strategies used for adults and how long these policies and procedures have been in effect	*Bidder demonstrates administrative competency in providing services to youth and families. Agency policies, procedures and treatment protocols have language that is specific to the effective engagement of and delivery of services to youth and families in areas such as access to services, use of particular strategies, medication protocols, consent for treatment, engagement of parents, referral out protocols, etc. These documents should generally demonstrate the bidder's inclusion of youth/family in care planning, demonstrate youth/family-specific practices, and should not serve as a barrier to care. (For example, if a policy indicated that persons under the age of 18 could not see the*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	psychiatrist, this would be a barrier to care and would not serve as evidence of competence.) ***2 possible points*** **High (2 points)** Evidence demonstrates competence in this area. Policies/ procedures/protocols have been in place for longer than six months. There is a full complement of policies/procedures/protocols that address services delivered to youth and families. **Med (1 point)** Evidence is supplied that demonstrates at least partial competence. Evidence is on-point, but data submitted indicates that some or all of these policies/procedures/ protocols were enacted in the past six months or are not yet in practice. There are some, but not a full complement of policies/procedures/protocols that address services to youth and families. **Low (0.5 points)** Response indicates understanding and commitment to effective engagement and delivery of services to youth, but evidence is minimal and/or is not specific to serving youth. **Not Met (0 points)** Evidence is not supplied, is insufficient, or not on-point in this area.		
3.5.3.5 Outcomes data, quality improvement processes, and	*Bidder demonstrates administrative competency in use of outcome, satisfaction and quality*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families	*measures that are specific to working with youth and families. Consumer satisfaction instruments can specifically measure youth/family satisfaction with services.* ***1 possible point*** **High (1 point)** Evidence demonstrates competence in this area. Outcome measures/survey tools have been in place for greater than six months. There is a full complement of tools used to measure these elements for youth and families. **Med (0.5 points)** Evidence is supplied that demonstrates at least partial competence. Evidence is on-point, but data submitted indicates that some or all of these outcome measures or survey tools are new in the past six months or are not yet in practice for youth and families. **Low (0.25 points)** There are some, but not a full complement of tools to measure these elements**.** **Not Met (0 points)** Evidence is not supplied, is insufficient, or not on-point in this area.		
3.5.3.6 Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician	*Bidder demonstrates administrative competency in assuring effective training, professional development and support in delivering services to youth and families at the supervisory and clinical level. This can be demonstrated in ways such as*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
levels in providing behavioral health services to children, adolescents, and their families. Evidence may include accreditation reports that speak to your work with youth and families and in-service training schedules or curriculums addressing the assessment and treatment of youth and families.	*but not limited to: submission of training schedules, training curriculum, copies of training certificates, and/or supervisory/ performance tools, achieving agency commendation for work with youth and families, copies of accreditation reports that highlight this expertise, letters of support from youth serving agencies or systems.* ***1 possible point*** **High (1 point)** Evidence is supplied that demonstrates a full complement of competency across the agency. Agency demonstrates recognition from accrediting bodies, peers or others for their work with youth and families. **Med (0.5 points)** Evidence is supplied that demonstrates partial competence. Bidder may demonstrate some, but not a full complement of competency across agency, supervisory and clinician levels, or there is limited depth of competency in these areas. **Low (0.25 points)** Experience is limited to one or two staff, or staff have training without much opportunity to use the training, or the agency has had some isolated recognition of these services from outside sources, but not sufficient to demonstrate regular recognition in this area. **Not Met (0 points)** Evidence is not supplied, is insufficient, or not on-point in this area.		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention 3.5.3.7.1 Résumés from current staff member(s) in your organization at director-level positions and above who have five or more years of experience providing behavioral health services to youth and families and would be involved in your organization's provision of Mobile Crisis Intervention	*Bidder demonstrates existing youth/family expertise within the agency. This must be shown by the submission of resumes from current staff members, who have had five or more years of experience providing BH services to youth and families AND will be involved in the provision of Mobile Crisis Services.* ***Note to reviewers – This question only has High, Medium and Low options for scoring.*** ***0.5 possible points*** **High (0.5 points)** Depth of expertise across <u>all</u> disciplines is demonstrated in resumes and active role in delivery of MCI services is articulated clearly. **Med (0.25 points)** Depth of expertise across <u>most</u> disciplines is demonstrated in resumes and active role in delivery of MCI services articulated clearly. **Low (0 points)** Evidence is not supplied, is insufficient, or not on-point. Resumes are generic in nature. Resumes are submitted, but it is not clear whether the person will be involved in the Mobile Crisis team.		
3.5.3.7.2 Job descriptions of any identified staff members who would be staffing the Mobile Crisis Intervention service in any	*Job descriptions for Mobile Crisis Intervention positions (Mobile Crisis Intervention program manager, child psychiatric clinicians, child-trained supervisors, child-trained clinicians,*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
capacity, including the Mobile Crisis Intervention program manager, child psychiatric clinicians, child-trained supervisors, child-trained clinicians, paraprofessionals and/or family partners	*paraprofessionals and/or family partners) are submitted. Job descriptions list duties and competencies that are consistent with the Mobile Crisis Intervention Service Definition and performance specifications.* ***Note to Reviewers: – This question only has High, Medium and Low options for scoring 0.5 possible points*** **High (0.5 points)** Job descriptions across <u>all</u> disciplines are comprehensive and reflect the core competencies, goals of the Mobile Crisis program and the performance specifications. **Med (0.25 points)** Job descriptions across <u>most</u> disciplines are comprehensive and reflect the core competencies, goals of the Mobile Crisis program and the performance specifications. **Low (0 points)** Evidence is not supplied, is insufficient, or not on-point. Core competencies within the job descriptions are generic in nature.		
3.5.3.8 Experience of integrating youth and family voice in organization governance. Evidence may include names and length of service of those currently on advisory boards	*This section is about integrating YOUTH/FAMILY VOICE in organizational governance and other documents submitted that demonstrate youth/family voice should be considered in this section.* *This may be demonstrated in ways such as but not limited to: evidence of youth/family membership on corporate board, committees, use of family partners in staff education, conducting open forums designed to seek*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	youth/family input, meetings with consumer advisory council. ***1 possible point*** **High (1 point)** Provider demonstrates successful ongoing means of integrating youth/family input in organizational governance **Med (0.5 points)** Provider demonstrates ongoing experience in integrating consumer input in organizational governance, but has not done so with youth/family representatives. **Low (0.25 points)** Provider demonstrates past experience (not current) in integrating consumer input in organizational governance. **Not Met (0 points)** Bidder does not describe any means of using input from youth/families or the description provided is inadequate, or what is described is unlikely to have an appreciable impact on organizational governance.		
3.5.3.9 Relationships with child- and family-focused community resources in the service area, including but not limited to, child-serving state agencies and social service providers, schools, residential programs, family and youth organizations, and pediatric primary care providers. Evidence may include demonstrated ability	*This section is about the Bidder Agency's CONNECTEDNESS with the broader youth behavioral health system and other documents submitted that demonstrate youth-specific intersystem connectedness should be considered in this section.* *Evidence may include but is not limited to bidder demonstrating: Strong level of connection with youth and family serving BH providers, strong level of connection with other youth-serving*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
to coordinate care and treatment across providers and service agencies, affiliation agreements with such organizations, and/or one sample of meeting minutes demonstrating integration with other organizations' focus on youth and family services. 3.5.3.10 Membership in child advocacy and/or child-focused trade organizations	*systems (DCF, DYS, DDS, DMH, schools, pediatricians, etc, membership in child advocacy or child-focused trade association.* ***1 possible total point for 3.5.3.9 AND 3.5.3.10*** **High (1 point)** Provider demonstrates clear connectedness with many other BH providers or systems and includes sound examples of cross youth-serving agency/system collaborations, affiliations, strategic initiatives; bidder identifies itself as a youth provider and demonstrates this through membership in child advocacy or child-focused trade organizations. **Med (0.5 points)** Provider demonstrates strong connectedness with youth serving agencies /systems but provider does not have an extensive youth component that identifies the agency as a youth provider. **Low (0.25 points)** Provider demonstrates some connectedness with some other providers or systems, allowing for flow of referrals, etc., but the relationship is not collaborative in nature or reached a point of the establishment of protocols, affiliation agreements or cross system/agency education. **Not Met (0 points)** Evidence is not supplied, is insufficient, or not on-point in any of the designated areas.		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.5.4 Mobile Crisis Intervention 3.5.4.1 Provide a brief program description that summarizes your planned Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services. Describe how you will provide a bi-disciplinary (clinician and family partner) intervention to engage and address the treatment needs of the child while also engaging, and supporting the experiences of the parent(s) whose child is in crisis.	*Essential components that should be conveyed in program description, philosophy and/or culture:* • *Strength's-based engagement of youth and families and respect for youth/family voice and choice* • *Understanding of resiliency principles* • *Services that have a goal of resolution, not merely an "assess and refer" approach to care* • *A commitment to providing intervention at the earliest point in the crisis* • *A commitment to providing up to 7 days hours of follow-up services to assure safety and effective linkages.* • *Commitment to delivery of crisis services in the natural environment* • *A commitment to finding the least restrictive disposition.* • *A commitment to reducing unnecessary use of hospital ED's and inpatient services* • *A commitment to effective crisis prevention planning* *Essential components that should be conveyed in the service delivery model and/or flow of service:* • *Mobile crisis services will be provided 24/7/365* • *Bidder conveys a high degree of flexibility in responding to the needs of*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	youth/families in their natural environment • *Commitment to rapid response (within expected parameters)* • *Bidder conveys a plan to maximize the use of the multidisciplinary team—both for expertise and efficiency in service delivery.* • *Mobile Crisis service is clearly tied to the greater ESP service* • *Bidder proposes a logical and efficient service flow from referral in—to service delivery—to referral out.* • *Model of care is described—specific techniques are named (Not limited to: wraparound principles, solution-focused interventions, CBT, Motivational Interviewing, Stages of Change)* • *Description addresses mental health AND substance use crises* • *Description addresses ability to serve special populations* ***4 possible points*** **High (4 points)** Most or all of the essential components are reflected in the Bidder's program description, philosophy and/or culture. What is proposed is clearly a youth/family-centric program that highly values family		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	preservation, and resolution-focused interventions. The description of the service delivery and/or flow of services (though brief) is comprehensive and conveys a strong sense of flexibility in service delivery, a commitment to assuring rapid response, commitment to continuity of care with referral sources, PCP's and any new providers. Bidder conveys a plan to maximize the use of the multi-disciplinary team. It is clear that the youth mobile team is a component of the greater ESP service. Bidder proposes a logical and efficient service flow from referral in to referral out. **Med (2.5 points)** Bidder's program description effectively addresses most, but not all of the values listed. .Bidder's description of the service delivery and/or flow effectively addresses most, but not all of the essential components listed. **Low (1 point)** Program description describes the program philosophy, culture, service delivery model and flow of services without much detail. Description lacks some essential components but touches on most, with minimal detail. **Not Met (0 points)** Program philosophy, culture, service delivery model and flow of services does not reflect many of essential components. OR Description does not specifically identify the program as specializing in services to children and families. Response does not evoke		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	commitment to supporting families in addition to youth in crisis.		
3.5.4.2 Describe how you shall manage staff resources to meet the variance in the needs of families and therefore the fluctuations in the intensity and duration of this service.	*(Note to reviewers—Bidder is not obligated to use a team of two for all interventions and description should reflect purposeful pairing of the professional and paraprofessional for some assignments, while giving separate assignments at other times. This is being described as "braided" staffing. Between 10PM and 7AM, bidders may propose to use on-call staff)* *Essential Components* • *Bidder proposal maximizes the use of both professional and paraprofessional staff—there is a delineation of roles and responsibilities.* • *Bidder effectively describes role of the Child Psychiatrist and/or child mental health Clinical Nurse Specialist—plan to assure response timeframes are met, and ability to access FTF appointment with the child psychiatrist within 48 hours, if indicated.* • *Bidder conveys an awareness of periods of peaks and ebbs in demand and proposes a staffing pattern that reflects this.* • *Bidder conveys an understanding that the actual number of hours of an episode (within the 7 day timeframe) will vary considerably*		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	and proposes a staffing pattern that reflects this. • *Bidder conveys a plan for managing the logistics of the service—assuring rapid initial crisis response, while providing effective follow-up care to other youth and families up to 7 days as needed and assuring continuity of care (i.e. assuring linkage, transfer of records, collateral consultation, etc).* • *Bidder may describe how the use of tools/technology will aid in program efficiency*. ***4 possible points*** **High (4 points)** Bidder conveys clear competence in managing the logistics of the program, has a clear sense of ebb and flow of demand and proposes a flexible staffing model that assures the team will address service demand. The proposed use of the Child Psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist is detailed and efficient. Mentions the use of technology in meeting service objective. **Med (2.5 points)** Bidder conveys fair understanding of the complexity of managing the program logistics. Though it may be lacking in detail or based on existing data, bidder anticipates ebbs and peaks in demand and proposes a staffing pattern to reflect these periods. Bidder proposes some delineation of		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	roles and responsibilities of professionals and paraprofessionals, but does not fully detail a plan for maximization of these positions. Use of child psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist is described, though not fully detailed. May or may not mention use of technology. **Low (1 point**) Bidder conveys cursory understanding of complexity in managing logistics of program, but plan to do so has some gaps and or does not provide enough detail to determine that bidder can formulate/ operationalize plan that will maximize use of professionals, para-professionals, Child Psychiatrist, and/or Psychiatric Nurse Mental Health Clinical Specialist and meet needs of program based on fluctuations in intensity and duration of service. **Not Met (0 points)** Bidder does not convey an understanding of the complexity in managing the logistics of the program. Bidder does not propose a plan that maximizes the use of the professional and paraprofessional staff to assure efficiency and timely response. Role of Child Psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist is not addressed or inadequate in detail. Bidder does not project an understanding of fluctuations in demand within the course of a day or week and a commensurate		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	staffing pattern.		
3.5.4.3 Describe how you plan to ensure that following an MCI intervention, for a calendar period of up to 7 days, the MCI shall provide continued intervention with a goal of crisis resolution, support family-specific alternatives to out of home placement, collaborate with other system providers to assure coordination of care stabilization and follow-up services. Address how you shall manage staff resources to meet the variance in the needs of families and therefore the fluctuations in the intensity and duration of this service.	*As they do in the initial crisis service, bidders may propose a flexible staffing model in order to provide support and follow up services over a period of up to 7 days* *Essential Components* • *Bidder proposal maximizes the use of both professional and paraprofessional staff—there is a delineation of roles and responsibilities in providing stabilization and follow-up services.* • *Bidder conveys an understanding that the actual number of hours of an episode (within the 7 day timeframe) will vary considerably and proposes a staffing pattern that reflects this.* • *Bidder conveys a plan for managing the logistics of providing follow-up services during the 7 days and families throughout the 7 days as needed and assuring continuity of care (i.e. assuring linkage, transfer of records, collateral consultation, etc).* • *Bidder may describe how the use of tools/technology will aid in program efficiency.* ***4 possible points***		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	High (4 points) Bidder conveys clear competence in managing the logistics of this aspect of the program, has a clear sense of ebb and flow of demand and proposes a flexible staffing model that assures the team will deliver stabilization/follow-up services over a 7 day period as needed. **Med (2.5 points)** Bidder conveys fair understanding of the complexity of managing logistics of providing stabilization and follow up services over a 7 day period, as indicated. Bidder anticipates ebbs and peaks in demand and proposes a staffing pattern to reflect these periods—but strategies to perform the services may not be fully formed. Bidder proposes some delineation of roles and responsibilities of professionals and paraprofessionals, but does not fully detail a plan for maximization of these positions. **Low (1 point**) Bidder conveys cursory understanding of the complexity of assuring stabilization and follow-up needs over 7 day period, but strategies are minimally detailed or lack complete credibility to ensure that services are maximized across all disciplines. **Not Met (0 points)** Bidder does not convey an understanding of the complexity of assuring stabilization and follow-up needs over a 7 day		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	period occur when indicated. Plan for flexible and efficient use of staffing is not conveyed.		
3.5.5 Describe how you shall establish linkages with other CBHI services including Intensive Care Coordination (ICC) as well as other child behavioral health services, and how you shall utilize these linkages to ensure care coordination, continuity of care, and diversions from inpatient psychiatric services and other out of home placement.	*Bidder conveys awareness of and commitment to achieving goals of CBHI services including ICC, and child CSS as follows:* • *Bidder conveys importance of identifying youth involved in or in need of services from multiple systems and/or at higher risk of out of home placement.* • *Bidder committed to facilitating effective linkage to CBHI and other youth services* • *Bidder conveys understanding of wraparound principles* • *Bidder conveys a commitment to establishing effective working relationships with CBHI service providers as well as other child BH service providers, knowledge of how to access the services, and the ability to describe the services to youth and families as effective alternatives to more restrictive settings.* ***3 possible points*** **High (3 points)** Bidder has a clear understanding of the goals of CBHI services, can fully articulate the goals of a wrap-around philosophy of care and sees the youth mobile crisis team as well positioned to identify youth and families who will benefit from the services—particularly those at risk of out of home placement. Bidder has		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	existing relationships with many providers of youth BH services and is prepared to educate youth and families and assist with rapid linkage to these services. **Med (2 points)** Bidder conveys fair understanding of the goals of CBHI services and a commitment to forming good working relationships and/or strengthening current relationships. Bidder conveys intention of identifying youth and families involved in multiple systems, and can articulate the basic goals of a wrap-around philosophy of care. **Low (1 point)**.Bidder has fundamental understanding of CBHI services and wrap-around philososphy, value of collaboration, but has few or no current relationships with providers of youth BH services, and does not articulate commitment and/or strategy to develop or strengthen relationships **Not Met (0 points)** Bidder does not convey an understanding of the array of youth and family services that are available in the community. Response reflects minimal understanding of the CBHI services, their purpose or how to access the services. Response does not reflect a value in seeking services that may provide a safe and effective alternative to more restrictive settings		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.6 Runaway Assistance Program (RAP) Describe how your ESP program shall operate a Mobile Crisis Intervention/Runaway Assistance Program ("MCI/RAP") 24/7/365 to youth between the ages of 6 to 18. Identify the manager as well as the number of on-call FTE separate from the MCI staffing dedicated to this program.	***1 possible point*** **High (1 point)** Demonstrates full understanding of the ESP/MCI responsibility to ensure staffing and responsiveness. References partnership with other components of RAP (Mass 2-1-1, Police, ALP). Identifies supervisor/manager to oversee RAP. **Med (0.5 points)** Good understanding of the RAP concept but does not identify manager to oversee/supervise and/or provides assurances of adequate staffing and timely response without expressing partnership with other components of RAP. **Low (0 points)** Partial understanding of ESP/MCI RAP response but no mention of collaboration with other RAP components. OR does not adequately address staffing, timely response, or oversight of program. **Not Met (0 points)** Has no idea how to indicate preparedness for RAP responses, or understanding the role of the ESP.		
3.6.1 Describe your experience in collaborating with local police departments, court clinics and DCF relative to youth served by your agency.	***2 possible points*** *Note to reviewers – if subcontracting MCI services, response should focus on and/or include subcontractor experience* **High (2 points)** Includes relevant examples of multiple collaborations with local police		

3. ESP Service Components (100 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	departments, court clinics and DCF relative to youth served by the agency; (If utilizing a subcontractor for MCI services, also includes relevant examples of collaborations by that agency) **Med (1 point)** Includes examples of collaborations that are not primarily youth focused but demonstrate ongoing collaborations with local police departments, court clinics, and DCF. **Low (0.5 points)** Includes some examples of relevant collaborations but not with all three entities and/or collaborations are not recent or ongoing, **Not Met (0 points)** Has no recent or relevant collaborations with local police departments, court clinics and DCF relative to youth or adults.		
		(Possible 100 pts.) Section 3 Total	

4. Additional response requirements, if applicable to bidder (considered but not scored)			
Question	**Scoring Guidelines**	**Comments**	
4.1 Hospitals as bidders 4.1.1 For hospitals that are bidding on an ESP contract, articulate how you are positioned to achieve the goals of ESP and this procurement, including diversion from hospital EDs and establishing a robust community-based presence.	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response –		☐ N/A ☐ Green ☐ Amber ☐ Red
4.2 Bidders submitting responses for multiple catchment areas 4.2.1 If your organization is the successful bidder in more than one catchment area, describe how this outcome shall affect your vision and organization of your ESP program, your implementation plan, and your staffing pattern. 4.2.2 Describe the strengths you would realize through serving multiple catchment areas from a quality and community perspective, and the efficiencies you would achieve.	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response		☐ N/A ☐ Green ☐ Amber ☐ Red

4. Additional response requirements, if applicable to bidder (considered but not scored)			
Question	**Scoring Guidelines**	**Comments**	
4.3 Subcontracts 4.3.1 For any ESP service component for which your organization plans to enter into subcontract arrangements with other provider organizations, detail: 4.3.1.1 The name of the subcontracting agency and main reasons for selecting this agency to perform the given ESP service component 4.3.1.2 The ESP service component(s) for which you plan to subcontract with that agency 4.3.1.3 Specifically if the subcontract will encompass the given service component for the entire catchment area and population, or if it is specifically for a specific population, geographic area within the catchment area (e.g. Designated ED), or other subset	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response		☐ N/A ☐ Green ☐ Amber ☐ Red

4. Additional response requirements, if applicable to bidder (considered but not scored)			
Question	**Scoring Guidelines**	**Comments**	
4.3.2 Describe how your organization shall, as the contracted ESP provider, oversee, monitor, and hold the subcontracted provider(s) accountable for all aspects of service delivery, including clinical, quality, and administrative.	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response		☐ N/A ☐ Green ☐ Amber ☐ Red
4.3.3 Given any planned subcontracts, summarize how your organization shall meet the requirement that you as the contracted ESP contract holder must propose a program model that ensures that your organization directly provides the majority of ESP services.	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response		☐ N/A ☐ Green ☐ Amber ☐ Red
		Section Total	N/A

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
1.Technology Infrastructure: ***General Specifications*** It will be important that ESPs have robust Information Technology (IT) infrastructure to ensure the efficient operations of all responsibilities and activities of the ESP, including: service delivery, flow of information, support of community-based interventions, record keeping, appointment scheduling, obtaining authorizations, data management and reporting, billing, and interface with the Virtual Gateway. 1.1 Please describe your organization's current IT infrastructure, including the following: 1.1.1 Staffing resources (number of IT staff, titles, and hours of availability of IT support)	***1 possible point*** **High (1 point)** Response details IT structure including staffing (# of staff, titles, hours of availability of IT support including on-call) and any other resources utilized by provider such as contracted services. Response ensures access to emergency support 24/7 if needed. **Med (0.5 points)** Response identifies staffing structure(# of staff, titles, hours of availability) of IT support but does not ensure 24 hour emergency support **Low (0.25 points)** Response partially answers question but does not address one portion – number of IT staff, titles or hours of IT support availability OR infrastructure is vague leaving questions about ability to provide adequate support for ESP services. **Not Met (0 points)** Response does not address more than one component of the question or does not reflect an adequate IT support system for ESP services.		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
1.1.2 Telephone (including availability of conference phones at your site)	Number of phones adequate for on-site staff on all shifts to have use of phone simultaneously. (8 phones) **Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response –		
1.1.3 Management information system hardware and software 1.1.3.1 Specify whether you have or shall establish LAN and/or WAN configuration and networking software.	***0.5 possible point*** **High (0.5 points)** **Med (0.25 points)** **Low (0 points)**	To be reviewed by IT	
1.2 Electronic medical record capacity 1.2.1 Describe your agency's information system with regard to collecting and tracking clinical data.	***2 possible points*** **High (2 points)** Provider already has an operational integrated electronic medical record that will be utilized by ESP upon implementation. Data collection is computerized and has capability to produce clinical data reports specific to ESP. **Med (1 point)** Provider in process of implementing electronic medical record and expects it to be operational at start of contract; Clinical data reports specific to ESP are a component of the system. **Low (0.5 points)** Provider has plan for EMR in future, but implementation will not occur at start of ESP contract. Provider may be able to track some		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	clinical data prior to EMR implementation. **Not Met (0 points)** No firm commitment to implementing EMR, still in planning stages; Minimal ability to track clinical data at this time.		
1.2.2 Describe your agency's ability to share this clinical data throughout your organization's system so clinicians have immediate access to clinical information	***2 possible points*** **High (2 points)** Agency has current operational system that allows clinicians immediate access to clinical information both on–site and remotely. **Med (1 point)** Agency is in process of making system operational that will allow clinicians immediate access to clinical information both on-site and remotely and expects it to be functioning prior to start of contract. **Low (0.5 points)** Agency has current system but it only allows limited access, primarily on-site, not remotely, for limited hours or not available to ESP clinicians; agency will likely have system operational for onsite and/or remote access for all ESP staff, but not by start of contract. **Not Met (0 points)** Agency does not have a system that allows clinicians immediate access to clinical information on-site or remotely, and is not able to predict if/when the ESP will have this		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	capability.		
2. Communications <u>Specifications</u> MBHP is committed to ensuring that all providers have equipment, policies, and procedures in place to ensure timely communication in both crisis and routine situations. This is essential to service delivery effectiveness as well as safety. Bidders should note that cell phones have been budgeted for all master's level clinicians and bachelor's level staff who work in Adult or Mobile Crisis Intervention. 2.1 Please describe your communications by answering the following questions: 2.1.1 Percentage of ESP clinicians who shall have on-site and remote access to e-mail ____%	***0.5 possible point*** **High (0.5 points)** 100% of ESP clinicians will have on-site and remote access to e-mail at start of contract. **Med (0.25 points)** 100% of ESP clinicians will have on-site access to e-mail but remote access will <u>not</u> be available to 100% at start of contract. Plan to obtain 100% within short time of implementation.(<30 days) **Low (0 points)** 75% - 99% of ESP clinicians will have access to e-mail on-site and/or remotely at start of contract. Plan to provide access to all clinicians will not be completed shortly after contract implementation. (>30 days) **Not Met (0 points)** No on-site or remote access to e-mail for 75% or more clinicians at start of contract,		
2.1.2 Percentage of ESP clinicians who shall have access to on site and remote access to voice mail ____%	***0.5 possible point*** **High (0.5 points)** 100% of ESP clinicians will have on-site and remote access to voice mail.		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	Med (0.25 points) More than 50% of clinicians will have access but not 100% **Low (0 points)** Less than 50% of clinicians will have access,		
2.1.3 Percentage of ESP clinicians who shall have cell phones with GPS ____%	***0.5 possible point*** **High (0.5 points)** 100% of clinicians will have GPS access via cell phones or other electronic devices at start of contract. **Med (0.25 points)** More than 50% of clinicians will have access but not 100%, at start of contract **Low (0 points)** Less than 50% will have GPS access at start of contract.		
2.1.4 Planned frequency of structured staff meetings with all ESP staff ____	***0.5 possible point*** **High (0.5 points)** Structured staff meetings with all ESP staff monthly or more. **Med (0.25 points)** Regularly scheduled staff meetings with all ESP staff less than monthly, but at least quarterly **Low (0 points)** No regularly scheduled staff meetings with all staff, or staff meetings scheduled less than quarterly.		
2.1.5 Percentage of ESP clinicians who shall have laptops or equivalent devices to perform required functions remotely. ___%	***0.5 possible point*** **High (0.5 points)** 100% of ESP clinicians shall have laptops or equivalent devices to perform required functions remotely. **Med (0.25 points)** 75% -99% of ESP		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	clinicians shall have laptops or equivalent devices to perform required functions remotely. **Low (0 points)** Less than 75% of ESP clinicians shall have laptops or equivalent devices to perform required functions remotely.		
2.2 Describe how your agency has put the above communication systems in place, including coordinating communication with MBHP. If your agency has no system currently in place, describe how you would put the above system in place, including implementation timeframes.	***1 possible points*** **High (1 point**) Clear description of implementation of communication system or clear, reasonable plan to implement communication system, including coordination of communication with MBHP. **Med (0.5 points)** Description of communication system implementation or plan, including communication with MBHP lacks some details that disallows total understanding of process. **Low (0.25 points)** Cursory description of communication system implementation or plan, with minimal reference to coordinating communication with MBHP **Not Met (0 points)** Description of implementation or plan lacking in detail, unclear, does not include fundamental information regarding implementation and/or communication with MBHP.		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
2.3 Identify the unique communications challenges you would expect in operating an ESP contract and the specific strategies you plan to implement to ensure timely and effective communication, to facilitate quality, service coordination, and safety.	***2 possible points*** **High (2 points)** Comprehensive, thoughtful response includes specific communications challenges and strategies to ensure timely and effective communication and facilitation of quality, service coordination and safety. Response is not "jargon" but demonstrates true understanding of the issues. **Med (1 point)** Response specifies communications challenges and strategies but does not include specific examples to ensure timely and effective communication and facilitation of quality service coordination and safety. Response is not "jargon" but demonstrates true understanding of the issues. **Low (0.5 points)** Response is basic, does not reflect depth of understanding regarding specific communications challenges and strategies, and/or how timely and effective communication correlates to all of the following: facilitation of quality, service coordination and safety. Response may contain "jargon" without substance. **Not Met (0 points)** Response does not demonstrate understanding of the		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	communication challenges and strategies and how they relate to quality, service coordination and safety.		
3. Provider Information Systems **<u>Specifications</u>** ESP providers shall be expected to have the capacity to perform the following function, and to implement these functions, as of the implementation date: • Electronic submission of claims – Please note that single-claim submissions require Internet Explorer 6 or better; batch (multiple) claim submissions require EDI software; requires Windows 2000 or Windows XP to run (earlier versions of Windows and Windows Vista are not compatible). Electronic submission of encounter form data Electronic Funds Transfer (EFT) <u>Additional software specifications</u> Providers shall need Internet Explorer 6 or better, e-mail, and an	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response		☐ N/A ☐ Green ☐ Amber ☐ Red

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
office suite of applications to handle any documentation sent to them or require from them. <u>Hardware specifications</u> Providers shall need sufficient PCs to accommodate whatever number of staff they have who shall need PC access. Additionally, bidders should note that laptops have been budgeted for all MS clinicians and BS staff who work in Adult or Mobile Crisis Intervention. 3.1 Describe your Management Information Systems (MIS) hardware by answering all of the following questions: 3.2 (Number of and identify all operating systems used) Servers ____ PCs ____ MACs _____ WS _____ Laptops _____ Tablets _____ Other _____			

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
3.1 Do you have enough PCs, laptops, and/or tablets to accommodate all staff that shall need to have computer access? ❑Yes ❑ No	***0.5 possible point*** **High (0.5 points)** Currently have enough electronic devices to accommodate all staff. **Med (0.25 points)** Do not currently have but commit to acquire prior to program start date. **Low (0 points)** Do not currently have enough electronic devices to accommodate all staff and acquisition will be delayed beyond start date of program.		
3.3.1 Do the laptops you provide in the field have broadband access directly through a wireless connection, so staff are able to access to any web-based applications? ❑Yes ❑ No If not, do you plan to provide this access? ❑Yes ❑ No	***0.5 possible point*** **High (0.5 points)** Currently has wireless access on electronic devices utilized in the field. **Med (0.25 points)** Does not currently have wireless access on electronic devices utilized in field but commits to having upon start of contract. **Low (0 points)** No wireless access on electronic devices utilized in field and no commitment to access upon start of contract.		
3.3.2 Do you have a hospital management system or an automated claims/billing system? ❑Yes ❑ No (asked to provide name of system)	***0.5 possible point*** **High (0.5 points)** Provider has hospital management system or automated claims/billing system; name of system included in response. **Med (0.25 points)** Provider does not		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	have hospital management system or automated claims/billing system, but will have in place at start of contract or presently has a system but did not provide name of system **Low (0 points)** No system, no commitment to have system at start of contract.		
3.4 Do you have 24/7 broadband access? ❑ Yes ❑ No (asked to provide maximum speed of system)	***0.5 possible point*** **High (0.5 points)** Currently has access with speed of 25 MIP **Med (0.25 points)** Currently has access with speed below 25 MIP **Low (0 points)** No current access		
3.5 Do you have web access? ❑ Yes ❑ No If no, would you acquire Internet access if required? ❑ Yes ❑ No	***0.5 possible point*** **High (0.5 points)** Currently has web access **Med (0.25)** Currently does not have Internet Access, committed to acquiring but cannot guarantee access upon start of contract **Low (0 points)** No Internet access, no plan to acquire access by start of contract.		
3.6 Do you currently submit claims electronically? ❑ Yes ❑ No If no, briefly describe your plans to	***0.5 possible point*** **High (0.5 points)** Currently submit claims to MBHP and/or other MCEs electronically		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
do so within ninety (90) days of the contract award.	**Med (0.25 points)** Do not currently submit claims to MBHP and/or other MCES but have systems and staffing capability to initiate at start of contract. **Low (0 points)** Do not currently submit claims to MBHP or other MCES and cannot guarantee capability at start of contract.		
3.7 If your organization is currently a contracted ESP provider, do you currently submit encounter forms electronically? ❑ Yes ❑ No If no, briefly describe your plans to do so within ninety (90) days of the contract award.	***0.5 possible point*** **High (0.5 points)** Current ESP provider that submits encounter forms electronically, or non-current ESP provider with capability and realistic plan to ensure system is in place within 90 days of contract award. **Med (0.25 points)** Non-current ESP provider without current capability and vague plan to ensure system is in place within 90 days of contract award. **Low (0 points)** Non-current ESP provider with no capability and unlikely to have system in place within 90 days of award.		
3.8. Do you currently receive payments via Electronic Funds Transfer (EFT)? ❑ Yes ❑ No If no, briefly describe your plans to do so within ninety (90) days of the contract award.	***0.5 possible point*** **High (0.5 points)** Currently receives payments via Electronic Funds Transfer **Med (0.25 points)** Does not currently receive payments via EFT but will have ability to do so at beginning of contract. **Low (0 points)** Does not currently have		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	EFT and cannot commit to having EFT at beginning of contract.		
4. Data and Information Management 4.1 For the following areas, please indicate whether your Management Information System (MIS) **is capable of producing** reports in each topic area. Then note whether your organization currently **uses** these reports for ongoing management and/or quality improvement purposes:	*On each of the 6 headings there is 0.25 points given for MIS capability and 0.25 points given if it is currently in use for a total of 0.5 on each topic*	[redacted]	
Financial reports	MIS Capability Yes 0.25 / No 0 Currently in use Yes 0.25 / No 0		
Utilization Reports	MIS Capability Yes 0.25 / No 0 Currently in use Yes 0.25 / No 0		
Clinician Profiling	MIS Capability Yes 0.25 / No 0 Currently in use Yes 0.25 / No 0		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
Client Profiling	MIS Capability Yes 0.25 / No 0 Currently in use Yes 0.25 / No 0		
Quality Measurements	MIS Capability Yes 0.25 / No 0 Currently in use Yes 0.25 / No 0		
Statistical Analysis	MIS Capability Yes 0.25 / No 0 Currently in use Yes 0.25 / No 0		
4.2 **Required attachment:** Please submit up to three of your most useful examples of MIS reports pertaining to some of the above categories	**Green**: No concerns about response **Amber**: Some concerns about response **Red**: RED FLAG – significant concerns about response		☐ N/A ☐ Green ☐ Amber ☐ Red
5. Encounter Forms MBHP requires completion of daily Emergency Service Program (ESP) Encounter Forms for every individual served. 5.1 Describe how your organization shall ensure completion of these forms according to MBHP policies and procedures, including staff training and complete and timely	***1 possible point*** **High (1 point)** Detailed response includes clear understanding of requirement, staff training including compliance component, and sound procedures to insure complete and timely electronic submission to MBHP **Med (0.5 points)** Response demonstrates understanding of expectation and provides some detail regarding staff training and compliance, as well as procedures to insure		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
electronic submission to MBHP.	complete and timely electronic submission to MBHP. **Low (0.25 points)** Response states that compliance will occur, but does not articulate realistic plan to insure training for and compliance by staff, OR sound plan for timely electronic submission to MBHP. **Not Met (0 points)** Response does not address staff training plan or ability to electronic submit to MBHP in complete and timely fashion.		
5.2 Describe your organization's capacity and planned practices to produce and use Encounter Form data for tracking, reporting, and quality improvement purposes, including your ability to report daily, monthly, and annually on encounter data by population, location, clinician, disposition, service component, and/or other variables as identified or requested.	***1 possible point*** **High (1 point)** Provider currently utilizes significant data for tracking, reporting and quality improvement purposes, with defined outcome targets; Provider clearly denotes how ESP data will be utilized for performance improvement by team and individual staff. **Med (0.5 points)** Provider collects some data for reporting purposes and applies data to quality improvement initiatives with targeted outcome measures in a limited fashion. Provider utilizes MBHP data to guide quality initiatives and performance improvement. **Low (0.25 points)**.Provider primarily utilizes MBHP data (or other outside agency) to review quality and		

Technology Specifications and Response Requirements (20 Points)			
Question	**Scoring Guidelines**	**Rationale for Scoring**	**Score**
	performance trends, but does not develop internal quality initiatives with outcome measures that will impact the data provided. **Not Met (0 points)** Provider does not have track record of collecting and/or utilizing data for quality improvement initiatives.		
			Technology Section Total (20 points possible)

Management Study

Executive Summary

This management study was developed to examine the Southeast ESPs current operating model and identify whether any efficiencies could be feasibly implemented in order to reduce operational costs without any adverse reductions in program services or quality. In 2014, DMH performed a similar review of its operations to identify similar types of possible operational improvement areas.[1] This management study builds upon many of the findings in that report and also draws from additional information gathered through interviews with program managers, key policy leaders as well as ESP stakeholder groups.

A number of scenarios were examined throughout the course of this study ranging from personnel restructuring efforts, service centralization, revenue recovery rate, and other efforts to increase general operational productivity. Following an examination of these various cost savings measures, and assessing the feasibility of their implementation, six primary efforts were identified resulting in an estimated projected net program savings of $904,120 in the first year following implementation and $2,108,816 over the three year projected transition period. Each year, savings are increased by the CMS Market Basket rate for cost of living adjustments reflected in form 2A.

	Year 1	Year 2	Year 3	Total Projected Savings
Shared Program Call Center	$441,935	$644,569	$390,239	**$1,476,743**
On-Call and Overtime Restructuring	$223,877	$0	$0	**$223,877**
Runaway Assistance Program	$141,904	$0	$0	**$141,904**
Staff Realignment	$43,365	$71,890	$10,985	**$126,241**
Revenue Recovering Maximization	$2,554	$25,268	$61,743	**$89,565**
Distribution of Laptops	$50,485	$0	$0	**$50,485**
Total Savings	**$904,120**	**$741,727**	**$462,967**	**$2,108,816**

Centralized Call Center: estimated $441,935 operating expense reduction in the first transition year and $1,476,743 cumulative over three transition years

This initiative envisions the establishment of a shared call center capable of servicing all four SE ESP service areas. This shared call center is meant to eliminate redundant program overhead and increase program efficiency by shifting significant administrative burden off of clinicians and onto specialized administrative staff. A shared call center would allow for effective triaging of patients, dispatching of mobile clinicians and by centrally coordinating the search for available bed space for patients in need, an activity currently requiring significant levels of effort. Some upfront costs would likely be incurred as a consequence of this effort however,

[1] Kappy Madenwald, Massachusetts Department of Mental Health, Emergency Service Program Performance Improvement Project (April 2, 2014).

these costs would be offset by clinician productivity improvements and longer term program savings.

On-Call and Overtime Restructuring: estimated $223,877 operating expense reduction over the three transition years

An examination of overtime levels was performed for fiscal year 2015 to assess the SE ESP's level of on-call and overtime expenses. The programs paid $787,766 in overtime to eligible employees during this period (approximately $5,865 per full time equivalent (FTE)). Much of this overtime pay was associated with on-call phone consultations and was exacerbated by the structure of the compensation model outlined in the collective bargaining agreement with the program's largest labor organization.
DMH recently implemented operational changes to its clinical on-call procedures in order to reduce the total number of consultations requiring overtime services. Previously, when a patient presented at a DMH location and was in need of a disposition or other intervention from a clinician after hours, an 'on-call' call was made to a clinician. DMH has since attempted to reduce the need for these on-demand calls in favor of holding set-scheduled calls on a regular basis where a single clinician can provide guidance for multiple patients arriving within the previous 24 hours. Additionally, efforts are being made to redistribute the scheduling of shift supervisors to allow their intervention for many overnight arrivals. Beyond these operational changes, proposed changes to the collective bargaining agreement governing overtime compensation would drastically reduce the amount of funds needed for this service in FY16 and beyond. All of these changes taken together would allow the program to maintain all service requirements, adhere to quality standards and reduce costs associated with overtime and on-call wages by nearly 30%.

Runaway Assistance Program: estimated $141,904 operating expense reduction over the three transition years

As a component of the MCI program, ESPs are responsible for providing assistance to runaway youth aged 6-18 through what is known as the Runaway Assistance Program (RAP). Currently, an external vendor provides this service through a yearly contract with the SE ESP. The current contract is based on an estimated volume of 96 RAP encounters per year across the four SE ESP catchment areas. These estimates however are significantly higher than the actual four encounters the program recorded during the first half of 2015. Although the program is new and still growing in terms of overall public awareness, DMH estimates that this program will not exceed 16 total encounters during future years. Given this projected volume, DMH believes its current SE ESP staff has the capacity to administer the RAP services internally, without the support of an external vendor. As a result, this project projects a one-time savings of $141,904 without any corresponding labor expense increases or reductions in program quality.

Staff Realignment: estimated $43,365 operating expense reduction during the first transition year and $126,241 cumulative over the three transition years

65.4% of total expenses across all four service locations are attributed to labor. In comparing SE ESPs to other regions of the Commonwealth, differences in staffing levels and productivity were identified across several areas, most notably among staffing levels of Registered Nurses (RN). The SE ESP program could realize program savings by shifting many responsibilities away from RNs toward more cost effective Licensed Practice Nurses (LPNs) over the transition years. As outlined in the statement of service and in program specifications, RNs are overqualified for many of the tasks they are currently performing, many of which would more appropriately align with the skillset of an LPN. The changes proposed in this intervention would take place as a result of expected program retirements and normal staff attrition.

Revenue Recovery Maximization: estimated $2,554 in additional revenues collected during the first transition year and $89,565 cumulatively over all three transition years

The SE ESP generates approximately $4 million in annual revenue through claims remuneration associated with insured patients seeking care at DMH sites. Current billing processes and FY15 potentially recoverable revenues by denial root cause were examined and opportunities to maximize collections were identified. Three primary causes of lost revenue were identified and assumptions were made on future recoverable possibilities based on potential program redesigns, technology investments and staff training needs. As recovery rates were scaled throughout the transition period, additional costs associated with the revenue recovery process were also included.

Distribution of Laptops: estimated $50,485 operating expense reduction over the three transition years

DMH incurs approximately $100,970 per year in clinician expenses associated with potentially avoidable drive times and mileage reimbursement incurred while performing mobile response services. Many of the hours and mileage associated with these response calls are due to a clinicians need to return to one of the four SE ESP office locations to enter encounter data into DMH's central record keeping systems. In an attempt to reduce this burden and save on program costs, DMH has begun distributing laptops to many of its clinicians to enable remote data entry in a secure and more efficient manner. Based on an analysis of total miles driven and associated reimbursement costs, this study identified the potential total costs savings associated with the use of these laptops among the program's mobile clinicians.

These six interventions together were estimated to accrue a projected net savings for the SE ESP of $904,120 in the first year following implementation and $2,169,111 over the three year transition period envisioned under this exercise. Additional details, assumptions and implications of each of these interventions are detailed throughout this study.

Shared Program Call Center

Overview:
The Southeast ESP locations in many facets, operate as separate entities despite their common management under DMH. This common relationship between the programs could be harnessed to enable some shared activities in an attempt to improve efficiencies and reduce costs.

Each ESP service location independently operates its own phone triage system and works to separately complete administrative tasks and perform bed searches as well as other referral activities. The Commonwealth of Massachusetts does not have a centralized bed search directory. Though one is reportedly under development, currently Clinicians and other staff inside the ESP are required to manually reach out to every known inpatient psychiatric facility as well as other community based providers in an attempt to locate inpatient psychiatric beds for patients in need of services. This activity requires a significant level of effort on behalf of many of the program's Clinicians and other staff. Additionally, many clinicians also spend time on other administrative tasks associated with receiving, transferring and caring for patients. With the establishment of a shared call center, many of these time consuming duties could be handled by a shared set of specialist staff, alleviating the labor burden on many clinicians.

The BMSC location, due to its current technical configuration and physical space capacity, is an ideal location for a potential shared call center. The center would operate between 8 AM to 8 PM Monday through Friday and would be staffed by two Clinical Social Worker (C)s and four Human Service Coordinator (C)s. This location would manage all incoming phone calls for the four program locations. Call center staff would be trained to dispatch clinicians from each of the four locations based on geographic location and need. Additionally, call center staff would manage registration and enrollment tasks associated with requests for services as well as direct bed search activities on behalf of clinicians across all four locations, removing further burden from clinical staff.

As a result of these shared services, it was assumed for the purposes of this study that productivity among the clinical staff would increase nearly 75%, as expressed in terms of encounters handled per shift over the programs transition period. It is anticipated that this shared center would allow for excess clinician capacity, alleviating the need for additional support staff and reducing excess staffing costs. It was projected that the development and use of the shared call center could result in nearly $1,476,743 in program savings over the course of the transition period.

Methodology:

Through program performance analysis, a clinician's productivity rate was observed to be approximately 0.7 encounters per shift (on an FTE basis), with significant additional administrative effort also associated with each of these encounters. As a result of the shared call center, it was assumed that clinicians could increase their ability to field encounters by 25% by the end of the first implementation year, 50% in year two and 75% in year three over baseline year zero levels. This increase in productivity results in an increase in the number of

encounters a clinician is capable of completing per shift, which in turn reduces the need for additional clinical staff. Overall patient volume was estimated to remain fairly stable over the transition period. By the end of the third year of the transition period however, the total number of encounters handled per shift across all programs will surpass current levels.

As outlined in *Table 1* below, this model anticipates the reduction of program's overall staff by 12.1 FTEs in year one, 8.0 FTEs in year two and 5.0 FTEs in year three. Accounting for the need for six call center staff, this would translate to an overall staff reduction of 19.1 FTEs over the programs transition period. Estimated cost savings have been expressed in both cumulative and annual savings.

The positions that will be affected by this productivity increase are the Human Service Coordinator (C)s, which provide many triage services, and the Clinical Social Worker (A/B)s, which provide the mobile services. Across all four programs, triage clinician productivity could result in a reduction of 18.1 Human Coordinator (C) FTEs and mobile clinician productivity increases could result in a reduction of seven Clinical Social Worker (A/B) FTEs, totaling the anticipated 25.1 reduction before netting out existing staff needed for shared call center staff.

Table 1: Projected Staffing Changes

	Year 0	Year 1	Year 2	Year 3
Clinician Productivity Increase	-	25%	50%	75%
Total FTEs:				
Human Service Coordinator (C)	40.1	29	25	22
Clinical Social Worker (A/B)	15.9	14.9	10.9	8.9
Clinician FTE Reduction	**-**	**12.10**	**20.10**	**25.10**

To calculate the cost savings that result from proposed FTE reductions, the average hourly rate of $30.60 for the positions referenced was used. In addition, calculating savings reflect salary payments made based on 40 hour work weeks for 52 weeks in a year (assuming holidays and sick days are compensated). Additional savings in fringe benefit payments were included as well using the FY16 fringe benefit rate of 29.17% for all three years of the transition period.

The shared center would be staffed by two FTEs of Clinical Social Worker (C)s and four FTEs of Human Service Coordinator (C)s, whose corresponding salaries would total approximately $519,522 per year, based on the average annual rates for these positions in addition to the projected Fringe Benefit expenses based on FY16 rates.

Table 2: Projected Annual Costs for Call Center Employees

FTEs	Title	Avg Hourly Rate	Avg Annual Rate	Total Cost
2	CSW C	$ 38.50	$ 80,100	$ 160,200
4	HSC C	$ 29.00	$ 60,500	$ 242,000
			Fringe Rate @ 29.17%	$ 117,322
			Total Annual Cost	**$ 519,522**

An additional $100,000 of equipment, technology and training costs will also be necessary. This cost has been distributed evenly throughout the three year period. Yearly and total savings associated with full implementation of the centralized call center as well as potential cumulative savings achievable over the three year transition period are outlined in *Table 3.*

Table 3: Projected Productivity Savings

	Year 1	Year 2	Year 3	Total
Cost Adjustment Factor		3.07%	3.04%	
Projected Productivity Savings	$994,791	$677,902	$423,572	$2,063,575
Projected Call Center Costs	($519,522)	$ -	$ -	($519,522)
Additional Costs	($33,334)	($33,333)	($33,333)	($100,000)
Net Savings	**$441,935**	**$644,569**	**$390,239**	**$1,476,743**

On-call and Overtime Restructuring

Current State:

Overtime levels were examined to identify possible inefficiencies among the SE ESPs compensation structure. In the previous budget year (FY15), the program paid a total of $787,766 in overtime, or approximately $5,865 per FTE. One quarter of this overtime was associated with clinical on-call consultations. Under the current on-call process, each consultation request is responded to at the time it is received by a clinician who is on standby. This standby pay is a substantial cost to the ESPs. Under the current collective bargaining agreement, clinicians on standby are compensated for their services in two hour increments of overtime pay regardless of the length of time of the actual call. Any calls exceeding two hours in length result in the clinician receiving an additional two hours of overtime compensation again, regardless of the actual length of the call.

In an attempt to reduce these overtime expenses, DMH recently began implementing changes to the clinical on-call consultation procedures. These efforts focused on establishing 1 hour on-call windows on both Saturday and Sunday to review dispositions from the previous 24 hours in lieu of on-demand calls based on patient arrival and in accordance with program operational specifications. An additional level of efficiency may also be gained by modifying the process through which shift supervisors are scheduled. As a proxy clinician for many on-call encounters, shift supervisors can provide needed services which if unavailable, require the assistance of an on-call clinician. All of the SE ESPs have second shift supervisors on site Monday through Friday who provide clinical consultation during their regular shift. However there are frequent gaps in supervisory coverage that result from scheduling issues, vacation time, and sick time. Establishing a single supervisor to provide clinical consultation for multiple programs at any given time would assist with ensuring that any variations in volume as a result of on-call needs would not drive additional overtime expenses.

These procedural changes will greatly reduce the need for on-call clinicians throughout the week and weekend. However the primary means through which the program could realize savings is through a change to the compensation structure for on-call services. In lieu of paying a minimum of two hours of pay at the employee's regular hourly overtime rate for any on-call work, or four hours of time (should the call require an in-person visit at the site of care), the SE ESP program could structure on-call coverage around a single flat $500 per week fee to each clinician providing a full seven day stand-by on-call consultation service across the four ESP service areas.

Through a restructuring of the SE ESP on call procedures and this shift in compensation to a flat weekly fee for coverage, the program could save $223,877 on costs previously associated with on-call consultations and overtime charges over the programs transition period.
As the vast majority of these calls require a simple disposition of patient condition, they do not require an in-person encounter and most can be adjudicated over the phone. However a minority of encounters do require additional in-person assistance. For the purposes of this study, it was assumed that this volume of in-person encounters would remain constant. As such, the additional in-person on-call compensation levels would not change.

Methodology:

Payroll data was examined for employees working at the four Southeast ESP programs for FY15. The Corrigan ESP was not found to have any unnecessary on-call costs associated, and therefore was left out of this analysis. The summary of the expenses related to on-call services are included in Table 4 over the course of six payment periods (12 weeks):

Table 4: Overtime and Standby Compensation by Employee

Program	2 – Week Period						TOTAL
	Weeks 11 & 12	Weeks 9 & 10	Weeks 7 & 8	Weeks 5 & 6	Weeks 3 & 4	Weeks 1 & 2	
Cape & Islands	$1,055	$1,436	$1,062	$2,381	$930	$1,473	
Brockton	$1,252	$4,795	$1,431	$3,892	$6,947	$780	
Norton	$2,882	$2,905	$7,203	$3,181	$5,308	$8,751	
Total	$5,189	$9,136	$9,696	$9,454	$13,185	$11,004	**$57,664**

Table 5: Cost Projections and Proposed Savings

	Average Cost per Week	**Projected Cost per Year**	**Proposed Savings**
Current Structure	$4,805	$249,877	-
Proposed Structure	$500	$26,000	$223,877

The data in these tables indicate a total expense of $57,664 in overtime and standby pay over the 12 week observed period. Annualizing this data lead to total estimated $249,877 worth of associated program costs to cover all on-call consultations. Assuming 12 weeks per quarter, this estimates total costs at $4,805 per week as exhibited in Table 5.

A key requirement to reducing the weekly call volume would involve expanding the roles of supervisors to provide consultation across multiple service areas. There will be no additional costs associated with the expansion of roles. Closing supervisory gaps will ensure that the average call volume between Monday and Friday remains low, as the lack of adequate supervisory coverage was the cause of several of the clinical consultation calls that occurred during the second shift.

With the proposed rate change for these on-call services and the revision of the on-call consultation procedure, the average cost per week would drop from $4,805 to $500 as the reduced call volume resulting from the procedural change will allow one designated clinician to field on-call consults across all four programs. This brings the projected cost per year down from $249,877 to $26,000 for an annual savings of 90% over baseline costs, or $223,877.

Runaway Assistance Program

Current State:

The Runaway Assistance Program (RAP) is designed to assist police officers assisting runaway children between the ages of 6 and 18. RAP provides a safe place where runaways can receive care on a voluntary basis until a transfer can be arranged to another appropriate service provider. The RAP program provides a safe location for these children and also an opportunity to conduct assessments to identify signs of mental illness or other areas requiring additional follow up.

Currently, the vendor Community Counselors of Bristol County (CCBC) is contracted to administer the RAP across the SE ESPs four service areas. Under their current contract, CCBC receives $141,904 annually for administering this program. DMH believes that due to the increasingly limited use of this program however, RAP no longer needs to be administered by an external vendor and instead could be administered by existing internal DMH staff. This would eliminate all of the $141,904 dollars spent annually to externally administer this program with no corresponding labor cost increases or reductions in service availability or quality.

Methodology

The current RAP contract with CCBC assumes a need for two RAP assessments to be conducted within each ESP location each month for a total of 96 annual assessments. Three full time staff members are provided under this contract, one responsible for providing primary on-call services and two serving as-needed support staff roles.

Actual volumes for RAP however have been significant lower than initial projections totaling just four encounters during the first two quarters of the 2015 calendar year. The program was not fully operational until April of that year however, so these anticipated volumes were inflated when annualizing to project 2016 annual volumes of 16 total encounters. This increase is based primarily on anticipated promotion of the program during the remaining months of 2015. Given these expected volumes, the SE ESP believes that existing staff capacity is capable of providing the continual supervision required during RAP encounters starting in 2016 and throughout the three year transition period.

As the current contract has only a single year term, this exercise assumes only a one year savings of $141,904 across the three year transition period.

Table 6: Proposed Savings

	Year One	Year Two	Year Three	Total
Net Revenue Gain	$ 141,904	$0	$0	$141,904

This contract has also not been included in future budget projections across the SE ESP program and thus was not included in the adjusted totals within the final cost forms in this submission packet.

Staff Realignment Analysis

Current State:

As labor remains the largest operating cost for the SE ESP programs, an examination of overall staffing patterns was conducted to identify any inefficiencies which if corrected, could result in program savings. When comparing the current SE ESP's staffing model to those outlined in the program's operational specifications, differences in staffing emerged indicating that certain realignments could be pursued resulting in program savings without a corresponding drop in program quality or service level. The largest impact in this area would be realized through the shifting of certain responsibilities from RNs to more cost-effective LPNs.

Two of the four SE ESP programs in particular, BMSC and Norton, staff RN's in positions that could be staffed with more cost-effective LPNs. By shifting these responsibilities following expected retirements and other natural staff attrition rates, the total dollars saved following this shift of service level positions is projected at $123,776 over the three year transition period.

Methodology:

The current budget year (FY15) is represented as "Year 0" in this modeling exercise. In Year 1, as a result of forecasted attrition among the nursing staff at BMSC and Norton ESPs, positions currently staffed by Registered Nurse IIs will begin to be filled by Licensed Practical Nurse IIs. The estimation is that one FTE for the Registered Nurse II position will be vacated per year, and the associated responsibilities could be assumed by increasing the number of Licensed Practical Nurse IIs by one FTE. This shift would continue in both years two and three across the BMSC program (table 7), while the Norton program, with only two Registered Nurse IIs, will have completed the transition by the end of the second year (table 8).

Table 7: Brockton Transition of RNs to LPNs

	Year 0		Year 1		Year 2		Year 3	
	FTEs	Total Salary	FTEs	Total Salary	FTEs	Total Salary	FTEs	Total Salary
Registered Nurse II	6.8	$ 864,971	5.8	$ 769,920	4.8	$ 656,734	3.8	$ 535,726
Licensed Practical Nurse II	3.0	$ 225,551	4.0	$ 313,924	5.0	$ 404,450	6.0	$ 500,100
Yearly Savings			**$6,678**		**$22,660**		**$25,359**	

Note that the yearly savings in Year 1 for BMSC is low due to the increase in fringe benefit rates for FY16. This FY16 fringe rate is used in the calculation of fringe benefits in Year 2 (FY17) and year 3 (FY18) as the rates for these years have not been released at the time of this analysis. Estimated cost savings could differ if fringe rates for transition years fluctuate significantly from predictions.

Table 8: Norton Transition of RNs to LPNs

	Year 0		Year 1		Year 2		Year 3	
	FTEs	Total Salary	FTEs	Total Salary	FTEs	Total Salary	FTEs	Total Salary
Registered Nurse II	2.0	$267,594	1.0	$139,627	0.0	$ -	0.0	$ -
Licensed Practical Nurse II	4.0	$299,451	5.0	$390,730	6.0	$483,268	6.0	$497,965
Yearly Savings			**$36,687**		**$47,089**		**($14,697)**	

Note that the decrease in savings for the Norton program during the third year of the transition period is a result of increasing salaries per the cost of living adjustment, not a change in staffing level.

Once potential savings have been calculated based off of staffing realignment, the effect on the cost forms is calculated by applying the CMS Market Basket rate for the cost of living adjustment.

Table 9: Total Transition Costs and Savings for BMSC and Norton Combined

	Year 0		Year 1		Year 2		Year 3		Total
	FTEs	Total Salary	FTEs	Total Salary	FTEs	Total Salary	FTEs	Total Salary	
Registered Nurse II	8.8	$1,132,565	6.8	$909,547	4.8	$ 656,734	3.8	$535,726	
Licensed Practical Nurse II	7.0	$525,002	9.0	$704,654	11.0	$ 887,718	12.0	$998,065	
Yearly Savings			**$43,365**		**$69,749**		**$10,662**		**$123,776**

Table 10: Cost Adjustment Factor

	Year 1	Year 2	Year 3	Total
Cost Adjustment Factor		3.07%	3.04%	
Previous Yearly Savings		$69,749	$10,662	
Cost Adjustment		$2,141	$323	
Yearly Savings	**$43,365**	**$71,890**	**$10,985**	**$126,241**

Assumptions and limitations:

Throughout this modeling exercise, several assumptions were made in determining final estimated savings. The total estimated amount of cost savings in this project has the potential to vary as the projections for the following categories of employee income were based on annualized data extracted from the DMH payroll system for FY14 (previous budget year):

- A07 (shift differential pay)
- A08 (overtime pay)
- AA1 (salaries: supplemental)

Should a significant variance occur within the last quarter of the year, many of the overall estimates for this particular study would be outside actual spending levels.

Additionally, this modeling exercise assumes the full implementation of the shared call center proposed earlier in this study. This call center would be essential in realizing the cost savings associated within this project in addition to savings associated with stand-by pay (known internally as A06) associated with nursing staff.

Finally, this exercise assumes no additionally incurred expenses related to training or other on-boarding costs typically associated with hiring new employees. It was assumed that due to position transitions coinciding with anticipated normal staff attrition and retirement events that these costs would be associated with normal operations regardless of any intervention and therefore did not need to be factored into this model.

Revenue Recovering Maximization

Current State:

Although the ESP program services significant numbers of uninsured and only provides a limited set of billable services for its patients, the program does submit claims for remuneration to both commercial and public payers. A review of a FY15 revenue recovery report as provided by the program's revenue cycle vendor highlights some potentially recoverable revenues which, should the program pursue substantial interventions, could be obtained, boosting the program's overall collection rates.

No potential recoverable revenues were identified across three of the programs service sites, however the BMSC catchment area did have associated recoverable revenues identified. The three areas most responsible for lost revenues, stemming from an analysis of denied claims, were:

- Claims submitted under clinicians who were either not enrolled in Medicare (a required condition for payment) or who were enrolled later than the service date;
- Claims submitted that did not have the appropriate prior authorizations included; and
- An 'other' category that was primarily self-pay referrals.

The root causes of these types of denials are typically associated with a number of operational aspects. Denials linked to improper clinician certification or licensure are typically due to out-of-date provider lists or the lack of a tool used in the claims submission process which reviews claims for this type of denial source. The ESP program would need to not only invest in obtaining or improving upon these processes, but would also need to retrain its billing personnel in their use and upkeep.

Attempting to mitigate denial volumes associated with prior authorizations also requires significant staff, process, and technology interventions. Prior authorizations are written orders from referring physicians that are used by insurance companies to ensure that a procedure is warranted, or commonly referred to as medically necessary. The collection and proper review of prior authorizations are typically carried out by registration staff who work in the patient access area of any provider location. These staff members are responsible for reviewing all patients (unscheduled and scheduled) records to ensure that the proper prior authorization has been given prior to receiving care. If those prior authorizations are not present in a patient record, registration staff are typically required to reach out to referring physician offices to obtain them. Additionally, scheduling and billing systems also need to be equipped to store and transfer authorization information in order to ensure that submitted claims contain this requisite piece of information.

The 'other' category of denials was primarily driven by individuals who received care and still carry a balance on their account. Typically this is associated with a practice's failure to collect co-pays or other out-of-pocket expenses from the patient at the point of care. This category also carries balances associated with individuals who were truly uninsured but through a payment program have the ability to pay off their balances in installments. It was assumed for

the purposes of this study based on typical industry collection rates that the revenues associated with this third bucket would not be feasibly recoverable.

This analysis acknowledges that improvements may require several years of technology investment, process redesign and extensive training initiatives before benefits could be fully realized; therefore, projections were scaled over a three-year implementation period. Projected revenue gains were forecasted over the three-year transition period as follows:

Table 10: Proposed Net Savings

	Year One	Year Two	Year Three	Total
Net Revenue Gain	$ 2,554	$ 25,268	$ 61,743	$ 89,565

Methodology

DMH submitted $8,634,848 in total claims during the FY15 service year. Overall potentially recoverable revenues during this time were identified as totaling $363,222.[2] Table 11 outlines these potentially recoverable revenues by root denial cause:

Table 11: FY15 Potentially Recoverable Revenue

Medicare Non-Enrolled Clinician	$44,274
Denial for No Authorization	$132,206
No Self-Pay Referrals	$186,742
Grand Total	**$363,222**

The table below outlines potentially recoverable revenues during the three-year implementation period should a robust intervention be successfully implemented across the SE ESP revenue cycle program.

The key assumptions driving possible recovery rates were:

- Medicare Non-Enrolled Clinician: It was assumed that given efforts to retrain staff, develop and maintain better record-keeping systems and implement new billing processes, the ESP could recover 50% of those claims previously denied for this root cause.
- Denials for No Authorization: Claims associated with a lack of prior authorization root cause were assumed to grow in terms of potentially recoverable revenue by 25% in year one, 50% in year two and 75% by year three. As previously stated, this would require ambitious program process redesigns and retraining effort of both patient access (registration staff) as well as billing (claim coding and submission staff) staff in addition to technology investments to update scheduling and billing systems to ensure claims are not submitted without requisite authorizations attached.

[2] Potentially recoverable revenue report generated by UMASS as DMH revenue cycle oversight vendor

- No Self Pay: It was assumed that none of the identified $186,742 total would be recoverable given the typical income levels of patients seen across the SE ESP catchment area and the operational difficulties associated with contacting and recovering out-of-pocket payments from the uninsured and underinsured.
- A 1.5% increase in revenues is assumed during each year of the transition period.
- An additional $100,000 cost for implementation and training was also included as a straight line amortized cost across all three transition years.
- Cost of living adjustments of 3.07% and 3.04% are applied to years 2 and 3 respectively to coincide with adjustments in the cost forms as well.

Given these assumptions, overall collections rates per year were assumed as follows:

Table 12: Recoverable Revenue by Root Cause

	Year 1	Year 2	Year 3	Total
Medicare Non-Enrolled Clinician	$22,469	$22,806	$23,148	$68,423
Denial for No Authorization	$13,419	$34,050	$69,122	$116,592
No Self-Pay Referrals	$0	$0	$0	$0
Training and Startup Costs	($33,334)	($33,333)	($33,333)	($100,000)
Total	$2,554	$23,524	$58,938	$85,015
Cost of Living Adjustment		$1,744	$2,805	$4,549
Total	**$2,554**	**$25,268**	**$61,743**	**$89,565**

Laptop Distribution

Overview:

The SE ESP reimburses many of its mobile service providers for their travel time and mileage associated with providing mobile services. Staff must frequently commute between the intervention location and the program office to document client encounters. Distributing laptops to all mobile clinicians to enable mobile documentation use through a secure method would build efficiencies for the Cape and Islands and Norton ESPs and result in overall cost savings from reduced work hours and overtime. Due to the short distances between most encounters occurring within the BMSC and Corrigan ESP locations, reimbursement and travel times were immaterial to overall program costs and not considered in this study.

Methodology:

A study was conducted by DMH to determine the total distance driven (in miles) by clinicians for on-call interventions over the course of a year. To estimate annual reimbursement costs associated with mileage, DMH compiled clinician travel distance for all interventions during fiscal year 2015 which totaled 185,104 clinician-miles per year. A portion of the potential cost savings achieved through the distribution of laptops would stem from the reduction in cost related to the reimbursement of mileage for staff. Based on the current mileage reimbursement rate of $0.45 per mile, DMH spends $83,297 per year on mileage reimbursement alone.

In addition to mileage reimbursement, DMH is required to provide reimbursements for regular use of vehicles incurred by clinicians incurred during trips. Compensation for this 'wear and tear' for the two programs totaled to $17,674 for total expenses in FY15 of $100,971:

Table 13: Annual Mileage and Associated Costs

Program	Annual Miles	Mileage Cost	W&T Cost	Total Cost	50% of Total
Pocasset	136,168	$61,276	$13,089	$74,364	
Norton	48,936	$22,021	$4,585	$26,606	
Total	**185,104**	**$83,297**	**$17,674**	**$100,970**	**$50,485**

In total, the Cape and Islands and Norton ESPs spend a combined $100,970 annually on costs related to staff travel. Due to intervals in the cadence of encounters, it was assumed that clinicians were typically driving to the location of the intervention, and then returning to their practice locations. The use of laptops would reduce the total number of miles driven by clinicians and associated costs by 50%, as clinicians will no longer need to complete clinical documentation for each encounter while physically at their home office. The Norton and Cape ESPs could realize a combined $50,485 in yearly cost and productivity savings through the distribution and use of laptops for clinicians. This analysis assumed full distribution of laptops across all clinicians and may include some savings already achieved through previously distributed clinician laptops. There are no purchase costs related to project implementation as these laptops have previously been purchased by DMH.

Addendum to the Management Study

Proposed Changes to Current Collective Bargaining Agreement

The Service Employees International Union (SEIU) Local 509 developed two proposals with the purpose of increasing efficiency and decreasing costs associated with the Department of Mental Health's Emergency and Mobile Crisis Intervention (ESP/MCI) Services in Southeastern Massachusetts.

- Proposal #1 is an amendment to the party's collective bargaining agreement
- Proposal #2 includes a series of proposed changes for inclusion in the management study.

This addendum addresses each proposal and comments on the feasibility and/or potential cost savings that could be achieved through the implementation of the proposal.

Proposal #1

This proposal is a contract amendment to Article 7 of the parties' collective bargaining agreement. The amendment proposes that call-back pay be compensated in the same structure as stand-by pay, and that the structure be changed to a $500 payment for a stand-by period with a duration of 7 days.

The management study, beginning on page 7, includes a reduction in the need for stand-by hours through a restructuring of supervisory hours and the inclusion of one designated employee that would handle clinician questions from all four programs. The proposal for a payment structure of $500 per week for these services would reduce these annual costs to $26,000, resulting in a cost savings of $223,877 related to costs previously associated with on-call consultations and overtime charges.

Proposal #2

The SEIU Local 509 on behalf of DMH ESP/MCI members are proposing a series of changes to be included in the management study. These proposals have been reviewed and assessed for feasibility.

1. **The creation and implementation of a centralized call center for On-Call Consultation**

    - **Problem**: Currently consultations are directed to an on call supervisor who then must address the situation as necessary. Each DMH catchment area currently must ensure that at least one qualified supervisor is available 24/7. This high demand in conjunction with the current call-back pay compensation leads to significant financial expenditure.

    - **Union Proposal:** The creation of a centralized call center would allow for incoming calls from all catchment areas to be filtered through one supervisor on-call. The one supervisor on-call would provide coverage for all the ESP sites

where there is not a psychiatrist providing this coverage. Staffing of this call center would be on a rotating schedule from the pool of qualified on-call supervisors from each catchment area. The supervisor on call would receive a weekly flat rate of compensation, pro-rated for coverage that is less than one week.

- **Assessment of Feasibility:** This perceived problem has been addressed within the *Centralized Call Center* section of the Management Study beginning on page 5.

2. Introducing an non-clinical support position for ESP/MCI Programs

- **Problem**: Under the current system, clinicians serve multiple clerical functions within the ESP programs in addition to their core function of conducting client evaluations. Currently, clinicians are forced to juggle their clinical work with other more clerical functions, such as faxing, data entry, and conducting bed searches. Technology that allows the clerical staff to enter the bed type during a bed search instead calling each place for a bed would also save considerable time.

- **Proposal:** Create a BA level position in order to handle duties that do not require the expertise of a trained crisis clinician. Tasks such as bed searches, filling out encounter forms for MBHP, getting insurance authorizations, file storage and faxing of documents, as well as other clerical duties would fall under the newly created position's responsibilities. This would enable clinicians to be more efficient with their travel time, cutting down on the response time to get to an evaluation, and being more available to be out doing evaluations. Because the clerical position would be at a lower pay grade, DMH would no longer pay for licensed clinicians to do clerical duties.

- **Assessment of Feasibility:** This perceived problem has been addressed within the *Centralized Call Center* section of the Management Study beginning on page 5.

3. Increasing technological capabilities in order to improve response time

- **Problem:** Currently the Brockton, and Cape and Islands catchment areas don't have adequate technology and this impedes their ability to work efficiently. Not having up to date functional laptops or tablets mean that clinicians are forced to trek back to their base of operations in order to write up every evaluation as well as the associated paperwork. This current system slows down a clinician's ability to be out in the community doing additional evaluations. Not only does this impact response time to a subsequent evaluation, it incurs unnecessary mileage costs.

- **Proposal:** Working laptops, or tablets would enable the clinician to enter the data once the evaluation is completed, avoiding the travel time needed to return to the office to enter data. Once the data is entered on the laptop or tablet, the clinician would go directly to the next evaluation, saving both time and mileage costs.

- **Assessment of Feasibility:** This perceived problem has been addressed within the *Laptop Distribution Resulting in Reduced Inefficiencies and Costs* section of the Management Study beginning on page 15.

4. The Offices on the Cape are not centrally located.

- **Problem:** Currently the Cape ESP offices are located in Pocasset and are not centrally located resulting in increased travel time for clinicians. This directly impacts response time due to clinicians needing to travel back and forth multiple times in a work day, also incurring avoidable mileage costs.

- **Proposal:** A centrally located office in Hyannis would alleviate the problem. Such an office would allow clinicians to spend less time on the road and more time evaluating clients; this would also serve to directly decrease response time, and reduce mileage reimbursement costs.

- **Assessment of Feasibility:** In the event that privatization does not occur, DMH anticipates renting a location in Hyannis and transitioning to this location in FY17. These rental costs have been captured on the Cost Forms for the Pocasset program.

5. Lack of coverage in Brockton

- **Problem:** Currently in Brockton there is a four hour coverage gap during third shift. This results in greatly increased wait times for clients who are seeking help during these hours.

- **Proposal:** Ensure that there is a clinician available 24/7 in order to assist people who are in crisis during normally unstaffed hours.

- **Assessment of Feasibility:** The current coverage gap cited in Brockton is the result of staff vacancies which, when filled, would eliminate the gap. There is no cost savings associated with this proposal.

6. Reintroducing comp time as an alternative to overtime.

- **Problem:** The collective bargaining agreement allows Management to determine whether or not an employee will be compensated through comp time or overtime pay. Management's current practice requires that the employee be compensated in overtime pay rather than comp time. The overtime costs have been exorbitant under this practice.

- **Proposal:** The Union is proposing that the practice allow for comp time accrual in lieu of overtime payment. Issuing comp time versus overtime would still be at Management's discretion, but changing the practice would allow for more flexibility to further reduce costs. The current overtime accounts for a significant portion of the ESP's costs; a system that encourages comp time would work towards reducing overall spending. This issue has been discussed between the Union and Management previously, and the Union proposes that it be revisited.

- **Assessment of Feasibility:** If implemented, this proposal could result in a cost increase for DMH. In the event that the use of staff comp time results in insufficient staffing for that shift, overtime costs would be incurred.

7. There is currently redundancy in managerial positions.

- **Problem:** Currently redundant or superfluous management positions create an environment which is both confusing for clinicians as well as both fiscally and operationally inefficient. For example, the position of MCI Area Director may be an unnecessary position with responsibilities that are duplicated by the MCI Site Program Directors, or easily transferred and within the skill set of the MCI Site Program Directors.

- **Proposal:** Eliminating the position of MCI Area Director who covers all catchment areas would free up resources. Currently four Clinical MCI Site Program Directors, staffed by highly skilled, independently licensed clinicians provide oversight and are qualified to incorporate any additional functions currently performed by the MCI Area Director. Additionally, the MCI Site Program Directors are not supervised by the MCI Area Director, and attend many of the same MBHP and MCI statewide meetings.

- **Assessment of Feasibility:** The *Centralized Call Center* section of the Management Study (page 4), proposes a solution to streamline processes among the four DMH ESPs to improve clinician productivity. It is anticipated with the increased productivity and the subsequent reduction of redundant staff as proposed in this section, there will be necessary adjustments to staff responsibilities, while the coordination of functions across the four program sites would still require area-based oversight.

8. Inflexible scheduling results in increased overtime.

- **Problem:** Not all Site Managers support flexible schedules. When employees are forced to regularly work shifts that align poorly with the needs of the workplace, overtime is used as the fall back for staffing resulting in higher than average costs.

- **Proposal:** Having flexible staffing patterns, such as those used at Corrigan Mental Health Center in Fall River, would allow for part time personnel as well as full time staff to easily switch shifts, creating a system that is conducive to minimal overtime usage.

- **Assessment of Feasibility:** This is addressed in the *On-Call and Overtime Restructuring* section of the Management Study beginning on page 7.

9. Current billing practices do not capture the full scope of billable activities.

- **Problem:** Currently DMH ESP miss billing opportunities because there is little formal training, or emphasis placed on the billing process. Funds are being lost due to inattention to what is actually billable.

- **Proposal:** A comprehensive seminar in conjunction with updated training for new employees would ensure that all clinicians are billing properly. Improved knowledge of the system would serve to increase reimbursement simply by billing for services that are already provided by clinicians. Accurate billing would provide revenue needed to upgrade more efficient technology such as laptops or tablets.

- **Assessment of Feasibility:** This perceived problem has been addressed within the *Revenue Recovery Maximization* section of the Management Study beginning on page 12.

10. There is no predictable way to handle surges in workflow.

- **Problem:** There is no way to adequately prepare for the natural surges in workload that accompany the ESP position. Some days will have as few as four calls while others may have ten times that number. This requires that all areas maintain enough personnel on staff should the volume on any given day be high.

- **Proposal:** An employee who is hired to be a “floater”, and who could cover all catchment areas, would greatly assist in this process. The “floater” employee would travel, as needed, to the catchment area(s) that were currently receiving the highest volume of calls. Creating one or two positions that are “floaters”

would also allow for coverage when there are multiple staff out on either discretionary or sick leave, and would allow for sufficient staffing during these times. The result would be a functionally more robust staffing pattern that reduces overtime costs.

- **Assessment of Feasibility:** This proposal may improve response times during peak demand but would not represent a cost savings for the purpose of the management study.

The Commonwealth of Massachusetts

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Compliance with Relevant Statutes

December 30, 2015

Honorable Suzanne Bump
Office of the State Auditor
State House Room 230
Boston, MA 02133

Dear Auditor Bump:

The Department of Mental Health certifies that we have complied with all the provisions of the Commonwealth's Privatization Law (Chapter 296 of the Acts of 1993) and all other applicable laws.

As reflected in the successful bidders' certifications, included in Section 8 "Summary of Bids Received," neither proposed bidder has a record of noncompliance with relevant statutes and is prepared to and will satisfy the requirements for quality. Furthermore, Boston Medical Center has a documented history of providing high quality ESP services in other areas of the Commonwealth where it is the ESP provider. Similarly, Community Counseling of Bristol County has a proven track record of providing high quality Mobile Crisis Intervention services (a component of the ESP) for which it has been a contracted provider.

Approved by:

Joan Mikula

DMH Commissioner

12-29-15

Date